ONTARIO

PROVINCE OF ONTARIO

THE MEDICAL SERVICES INSURANCE ENQUIRY

Proceedings of the Public Hearings
held at the Galbraith Building,
University of Toronto,
Toronto, Ontario, at 10:00 a.m.
on Tuesday January 28 1964.

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THE CHAIRMAN: Is the delegation here from the Physicians' Services Incorporated, and if so we would like you to come forward to the table.

You all have a copy of the statement setting out the procedure. In accordance with the statement that you have there, would the individual who is to make your presentation please identify himself, and introduce your colleagues.

SUBMISSION OF PHYSICIANS' SERVICES INCORPORATED

Appearances: Dr. J.O. Lockhart, Dr. W.B. Stiver,
Dr. R.M. Hines,
Mr. E.T. Williams,
Mr. C.A. Bond.

DR. LOCKHART: I am Dr. Lockhart, President of P.S.I.; on my right is Dr. Hines, a member of the Board of P.S.I.; next is Dr. Stiver, Medical Director of P.S.I.; on my left is Mr. Bond, the Assistant Secretary-Treasurer of P.S.I.; and next to him is Mr. Williams, the Enrolment Manager of P.S.I.

THE CHAIRMAN: Now if you wish to proceed, and if you wish to be seated, just please yourself.

DR. LOCKHART: Mr. Chairman and members of the Committee: Throughout our submission we have made various recommendations relating solely to the service concept of prepaid medical care. If any of these recommendations is not

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implemented the entire service principle as established by the medical profession and as exemplified in the majority of the non-profit doctor sponsored plans across Canada would be seriously disrupted if not destroyed. Because of the prime importance to the public of maintaining the service principle in Bill 163 we would like to amplify and clarify the meaning of a "service carrier".

There are several important points involved.

1. There must be participating physicians, i.e., physicians who have signed an agreement which includes two main principles -- (a) the physicians agree to forego temporarily or permanently a percentage of their allowed accounts to cover administrative costs for a part of the stabilization reserves. In addition they accept the principle involved in underwriting agreements that under emergency conditions their allowed accounts may be pro rated to protect the service plan from financial embarrassment, and -- (b) the physicians agree that unless it is otherwise set out in the subscribers' agreement, they will accept the payment of the service plan as full and final for the services rendered. Paragraphs 29 - 34 on pages 6 and 7 of our submission go into the details of this arrangement.
2. There must under Bill 163 be free choice of physician and this will mean that some subscribers to the standard plan enrolled through the service plan will use the services

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2. There must under Bill 163 be free choice of physician and this will mean that some subscribers to the standard plan enrolled through the service plan will use the services

of non-participating physicians. It is our opinion that because of the underwriting principle inherent in the participating physicians' agreement the service plan cannot pay to the subscriber who has received services from a non-participating physician a greater amount than it would have been obliged to pay to the participating physician for the same services. Paragraphs 103 to 105 on page 43 go into this in detail. There must be sufficient "participating physicians" to make a "service plan". It is generally conceded on this continent that an organization cannot be considered a service plan unless it has over 51% of the physicians practicing in its area of influence signed up under a participating physicians' agreement.

In order for the service approach to be effective in Bill 163 the standard medical services insurance contract should be of two types: one type would be used by the carriers whose organizations do not depend on having participating physicians; the other would be used by the "service" carriers whose organizations do depend on having the majority of physicians participating with them on a "participating physicians' agreement" basis.

There is, Mr. Chairman, another point on which we would like to comment and that is that under article 3(b) of Bill 163 it is provided that the Minister may contribute to the purchase of Standard Medical Insurance contracts

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for those persons who are in needy circumstances. We feel this is quite commendable but as the Act is now worded the subsidization would present a problem to all carriers. The Act provides that a subsidy would be granted only in the case of purchasers of the standard medical contract; however there are many thousands of persons covered under medical service insurance contracts that have benefits equal to or greater than the proposed standard contract. There is also a large number of persons employed in existing groups who would because of their low earning power qualify for the subsidy. If Bill 163 will not provide this subsidy to the individual who is carrying a coverage that is equal to or greater in benefit than the standard plan his only choice will be to drop out of the group and carry the standard plan on an individual basis.

This procedure would upset considerably the normal group regulations and as the government has intimated that it wishes to disturb the present operations of the carriers as little as possible we feel that this area must be taken into consideration. We therefore recommend that the subsidy be applied to those persons who qualify and who are carrying medical coverage equal to or greater than the Standard Medical Services Insurance contract.

A third point which we neglected to include in our submission is the composition of the Board of Directors of

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M.C.I.

As we have already mentioned the service approach to prepaid medical care is distinct from that of any other type of carrier and this distinction should be reflected in the composition of the directorship of M.C.I.

The voting power of the directors of M.C.I. should be arranged so that the service organizations and/or the other carriers cannot out-vote each other but would be forced to solve their differences through compromise.

We therefore recommend that:

The Board of Directors of Medical Carriers Incorporated consist of seven persons, as follows:

Three representing the service plans -

2 of which will represent P.S.I. and

1 of which will represent W.M.S.

Three representing all other carriers -

2 of which will represent C.H.I.A. and

1 of which will represent the other carriers;

with the addition of one who will be elected by a unanimous vote of the above six directors to act as a non-voting president.

Each director representing the carriers would be entitled to one vote at all meetings of directors.

Mr. Chairman, we appreciate very much the privilege of appearing before you, and are prepared to answer

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any questions on our presentation.

THE CHAIRMAN: Thank you. Mrs. Aylen?

MRS. AYLEN: Thank you Mr. Chairman. This is a pretty comprehensive brief. I must say it kept us very busy reading it, and there is a tremendous amount of information in it.

Some of us have picked out some particular points and have the privilege of asking questions on them. I am particularly interested in the subject of periodic check-ups, or health examinations, and there seems to be quite a difference of opinion on whether they should be included, or not included in Bill 163, and I would like very much for you to elaborate on what really constitutes a periodic health examination, or at least give us your opinion.

DR. LOCKHART: The answer to this question is almost impossible to give, as to what constitutes a periodic health examination, and the first point is that this is on the volition of the individual, and we feel that this is probably not, for this reason, an insurable item.

Now, the other phase of it, what constitutes a periodic health examination, can vary at anything from a very casual, superficial glance over the patient, to a very intensive investigation, involving two, three or four days in the hospital, with any number of additional medical examinations.

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very difficult to define, and we've come to the conclusion that we have for these reasons, and also feeling that the availability of ready medical care, the first dollar coverage at the first sign or suggestion of anything wrong, is a much better preventive public health measure than so-called periodic examinations, and this is provided in our present program.

MRS. AYLEN: On page 54, paragraph 139, this has to do with referrals and you say: "The article should be clearer. It is necessary that the term "referral" be defined in a practical manner."

Would you suggest how that should be defined?

DR. LOCKHART: No. We feel that we should not be the ones to necessarily define what the meaning is. However, we are quite concerned that the point be clarified, and preferably I think by the medical profession themselves, so that it can be administered in any insurance program, and this is why we feel it should be specifically defined, but that we can administer it once it is defined in a manner that can be commonly utilized by all.

There is a difference of opinion in what referral means, but I think a solution to this, and I am sure that the Ontario Medical Association would add the clarifying points to this question.

THE CHAIRMAN: Could you give us an example of how you think it might be interpreted, or misinterpreted?

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THE CHAIRMAN: Could you give us an example of how you think it might be interpreted, or misinterpreted?

DR. LOCKHART: Well, it can be misinterpreted very commonly by what we call a transfer, a patient seeing one doctor, and a particular type of treatment. He's not necessarily within the field of that doctor, and he may transfer to another doctor for that particular specific case, whereas the traditional role of referral and consultation was the seeking of advice of another doctor.

MRS. AYLEN: To go back to page 48, paragraph 120: "It is set forth that a local municipality MAY purchase or contribute to the purchase of the standard plan."

I take it that you recommend that this should be that they must, and would you tell us why, and have you had any difficulties with the Ontario Hospital Services Plan?

DR. LOCKHART: Well, my understanding is that in the Ontario Hospital Services, the condition is made, and various municipalities may handle this differently. Some municipalities, I understand, do purchase Ontario Hospital coverage. Other municipalities do not purchase it for those people whom they have the responsibility for, but rather when the patient is admitted to hospital then they pay the statutory rate, and we feel that either this recommendation which we have put down, that the municipality must purchase coverage, would make a uniform method of looking after it across the province, rather than having some municipalities purchasing coverage and others not.

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MRS. AYLEN: Does it make any difficulty with the municipalities?

DR. LOCKHART: This is probably true, and there may be other means of doing this, but I feel that this is something to be ironed out by this Council.

DR. BUTT: On your first page of recommendations, you wish Schedule B to be eliminated. I presume that would be the way to describe it?

It's the 7th recommendation of the summary, right, right at the beginning. Schedule B is to be eliminated from the standard plan. Would you tell us why?

DR. LOCKHART: Mr. Chairman, I think our reasons are fairly well outlined on page 38, why we feel that it should be done.

DR. BUTT: I think this is more for the record. We've had considerable controversy about this from other briefs.

DR. STIVER: Mr. Chairman, I think two or three main points are given on page 38. It's a type of contract, a limited contract, that I think does develop discrimination and inflation, and I think anti-selection is one of the great points. The second one is that it is not conducive to preventive medicine because there's no home and office service there. It's purely hospitalization, and then of course we have the problem of the distribution of hospital

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beds.

In the past we've been chided for selling such a plan where there were no hospital beds available, or there was a great delay for emergency -- or not emergency, but elected work.

We feel that a plan that has the endorsement and sponsorship of the Government of this Province should probably be comprehensive care, rather than a limited schedule.

DR. BUTT: It's your main reason when you deal with anti-selection, having the patient in hospital and therefore selecting against hospital beds?

DR. STIVER: No, we think of a family saying to itself "I don't need care for the ordinary things. I'll take a chance on that, but I do need something to cover me when I need major surgery."

DR. BUTT: Yes, but this has nothing to do with the argument of the beds available, which is anti-selection in certain areas.

DR. STIVER: Yes.

DR. BUTT: Do you think this would be a suitable policy for somebody who was sort of budgeting against a chronic illness, and a specific policy was produced to that effect?

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It's again page 43, but I am just reading off the recommendations to facilitate the matter.

DR. LOCKHART: Yes, we feel that the service plans, having been doctor-sponsored plans developed by the doctors, that this particular philosophy and the other features of the profession, being the development of the service plans and the direct payment to the physicians by the service plans, and the responsibility that the physicians carry to the service plans, we feel that this principle should be maintained.

DR. BUTT: This is again a private contract between you and the doctors?

DR. LOCKHART: Yes.

DR. BUTT: And the responsibility of the municipalities, you feel that they are obligated to carry this, and that they must pay the premiums at that level.

Is this what you are trying to say?

DR. LOCKHART: If the Bill as written, is passed, then we feel that for those people, if for instance the Provincial Government is going to accept the responsibility, as they suggest, to one level, and if certain people -- and these are delineated -- are they the responsibility of the

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municipality? Then the municipality should accept that responsibility, and we feel that probably the easiest way to accept that responsibility would be to purchase coverage on the same way that we are interested in the implementation of the Act, that the Provincial Government will purchase coverage for those people they are responsible for.

DR. BUTT: You are referring then not just to Schedule C?

DR. LOCKHART: That's right.

DR. BUTT: You are referring to those who aren't Schedule C, but might become a municipal responsibility by virtue of their lack of financing at that particular moment.

Is this the group you are talking about?

DR. LOCKHART: Yes.

DR. BUTT: You feel that this should be insurance bought, and the premiums paid by the municipality?

DR. LOCKHART: Yes.

MR. WHITNEY: Does that exclude Schedule C?

DR. BUTT: That excludes Schedule C. Schedule C shall remain at whatever way, but this has to with those at that particular moment.

THE CHAIRMAN: Wouldn't these be people, for instance, who might be temporarily out of work? Would they probably be included in that?

DR. LOCKHART: Some of these are, yes.

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MRS. CAMPBELL: Wouldn't these be people, for instance, who might be temporarily out of work? Would they probably be included in that?

DR. LOCKHART: Some of these are, yes.

THE CHAIRMAN: Well, how would the municipality buy insurance for them on a temporary situation like that, assuming that when they go back to work, why, they might be insured under a group plan..

Would it be possible for the municipality to buy group coverage without naming the individual?

DR. LOCKHART: It might be possible to do that, but it would be much easier if the individual had a standard plan for the municipality to carry on the payments of the standard plan during this temporary period of responsibility of the municipality.

In the other way, the individual could be transferred into a municipal group, and his payments continue.

MR. CASWELL: This would suggest, as I understand now, the municipality is responsible for so-called welfare cases. This would suggest that as soon as a man is out of work for the municipality to accept that responsibility he becomes a welfare case. He might have been earning $175.00 a week, and he's out of work for sickness.

Would you suggest that he is a welfare case because he is out of work for six weeks, and the municipality should pay for his coverage?

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MR. CHAIRMAN: This would suggest, as I understand now, this whole policy is responsible for so-called welfare cases. This would suggest that as soon as a man is out of work for the municipality to accept this responsibility he becomes a welfare case. He might have been earning $215.00 a week, and he's out of work for sickness.

Would you suggest that he is a welfare case because he is out of work for six weeks, and the municipality should pay for the coverage?

DR. LOCKHART: Not necessarily. I think the provisions are already there and already existing in the municipalities, which determines when this individual becomes a welfare case.

MR. CASWELL: That, I agree with. But I understood from you, perhaps incorrectly, that in order for him to carry on his insurance, once he goes out of this group because he was laid off and was out of work, that he could carry it through the municipality?

DR. LOCKHART: This is one way which it could be done for those people who are the responsibility of that municipality. On the other hand, in our contracts the individual, if he leaves a group, is allowed portability and can carry that contract on himself.

MR. CASWELL: I appreciate that.

DR. LOCKHART: This would only be those people for whom the municipality has a responsibility.

DR. BUTT: It would be only those that they would pay for anyway?

DR. LOCKHART: That is correct.

DR. BUTT: I do not think it is any more than that that they are referring to. Now "carriers' limited when the resident leaves the Province..." Now, just what do you mean by this. Do you feel that when the person leaves the Province the carrier has no responsibility? I believe your

DR. [illegible]: Not necessarily. I think the provisions are already there and already existing in the [illegible] multiplicities, which observe when this individual becomes

MR. [illegible]: That, I agree with. But I understood from you, perhaps incorrectly, that in order for him to carry on his insurance, once he goes out of this group because he was laid off and was out of work, that he could carry it through the municipality?

DR. [illegible]: This is one way which it could be done for those people who are the responsibility of that municipality. On the other hand, in our counties the individuals, if he leaves a group, is allowed portability and can carry that coverage with [illegible].

DR. [illegible]: [illegible] that.

MR. [illegible]: [illegible] would only be those people for whom the municipality has a responsibility.

DR. [illegible]: It would be only those that they would pay for anyway?

DR. [illegible]: That is correct.

DR. [illegible]: I do not think it is any more than [illegible] the carriers not to responsibility. I believe your

contract says "world-wide coverage".

DR. LOCKHART: Our feeling is that where a resident changes his residency from the province to elsewhere, that he should be only covered for three months. On the other hand, where he is only temporarily -- on an extended vacation, and he has not changed his residency...

DR. BUTT: Legally domiciled, in the term that the Federal Government uses; is this what you are talking about? How are we going to define this? There are certain definitions for an election, certain ones for immigration; which one are you going to take? I am not disagreeing with you. This is just for clarification.

DR. LOCKHART: This is a detail that would have to be delineated. We feel that when the individual is just away on vacation, his policy should carry on if he is temporarily away.

DR. BUTT: Six months, for instance?

DR. LOCKHART: I do not think there should be a time limit. As long as he maintains his residence in the Province of Ontario, then he should be allowed to have this coverage; but if he moves away and he has changed his domicile, then three months should be the termination.

THE CHAIRMAN: Do you have a clause like this in your own contracts?

DR. STIVER: We have a residency clause, yes.

DR. [illegible]: Our feeling is that where a
president changes his residency from the province to elsewhere,
that he should be only covered for three months. On the other
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Province of Ontario, then he should be allowed to have this
coverage; but if he moves away and he has changed his domicile,
then three months should be the termination.

[illegible]: Do you have a clause like this

[illegible]: We have a residency clause, yes.

But we administer it very liberally. We do not have much trouble with it because a subscriber generally comes right out and tells us what he is going to do.

THE CHAIRMAN: You do not put any limitation in your contract?

DR. STIVER: No. Now, if he says "I am going to Florida for four months", and at the end of eight months he is still there, we would write him a letter and ask him if his plans have changed, and if he comes back and says "Yes, it looks as though I am going to stay here for two or three years", then we suggest that he transfer to one of the Blue Shield Plans in Florida.

That is the way it works in P.S.I. We see no reason why it couldn't work that way. It is an administrative chore to watch those people.

DR. BUTT: It is just a matter of getting clear what you have in mind so that we can recommend it.

DR. STIVER: I think the reason that the President didn't want to tie it down is that we have cases in which employees are loaned, under the Colombo Plan or under the United Nations, from Ontario, from some of our groups and they may be in Iraq for two or three years, say; but, yet, they still have a residence, to all intents and purposes. I suppose they rent their house. We consider they have a residence in Ontario. They are paid here and everything else. We have said

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"Yes, you can continue with your P.S.I." But these are individual cases and I think the Board deals with them on the merits of the individual case.

We may be too generous, is what you are thinking?

DR. BUTT: No. I want to clarify exactly what you have in mind. I am just taking the recommendations and trying to pin them down exactly: "A resident who purchases a standard medical services insurance contract shall include in his agreement as eligible dependents..." Again, I am just taking the recommendations. On page 51 is where you refer to it in detail. What is the obligation you feel that they have to enrol their dependents?

DR. LOCKHART: Again, we feel, as written, that a resident should, if he is going to purchase standard medical insurance, should cover in his agreement his spouse and all his dependents up to the age of 19.

DR. BUTT: This is his own obligation?

DR. LOCKHART: Yes, his own obligation.

DR. BUTT: And that he can cover himself and that alone?

DR. LOCKHART: That is right.

DR. BUTT: Fine.

MR. MAJOR: May I ask a question on residency for one point of clarification? I think it should be brought

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DR. FOTT: No. I want to clarify exactly what you have in mind. I am just feeling the recommendations and saying to pin them down exactly: "A resident who purchases a standard medical services insurance contract shall include in his agreement no eligible dependents..." Again, I am just taking the recommendation. On page 21 is where you refer to it in detail. What is the obligation you feel that they have to cover their dependents?

DR. LOCKWOOD: Again, we feel, as written, that a resident should, if he is going to purchase standard medical insurance, should cover in his agreement his spouse and all his dependents up to the age of 19.

DR. FOTT: Then is his own obligation?

DR. LOCKWOOD: Yes, his own obligation.

DR. FOTT: And then he can cover himself and that alone.

DR. LOCKWOOD: That is right.

DR. MACKAY: May I ask a question on residency

out that in North America, including Hawaii and some of the West Indies, there is now in practice a method whereby people are transferred from one pre-paid insurance plan to another on a three-month basis. This is now a fait accompli and it works very well throughout the North American continent. So that what has been suggested in this brief is a practical suggestion that is now in operation.

DR. BUTT: I won't pursue that one any further.

Then on page 62, again, your last recommendation: (Reads). The first question is what do you feel about pooling of those over 65?

DR. LOCKHART: Mr. Chairman, we have had some look at pooling without knowing too many of the details and I think we have agreed that as long as the arrangement of pooling does not work a hardship or alter our contracts, from the point of view of our subscribers, that with certain possible modifications we approve of pooling in this particular contract. After all, P.S.I. is built upon the principle of pooling within ourselves. As far as the detail of the question regarding the other statement, I would like to have Mr. Bond answer that.

DR. BUTT: The second question would be : How would you identify those under 65 whom you feel -- I presume you can use the word high-risk, from the insurance standpoint?

out there in North America, including Hawaii and some of the West Indies, there is now in practice a method whereby people are transferred from one pre-paid insurance plan to another on a three-month basis. This is now a fait accompli and it works very well throughout the North American continent. So that what has been suggested in this brief is a practical suggestion that is now in operation.

MR. BOND: Yes. This is the problem that could be created for the community-rated plans in which we could not identify the individual that would be in this high-cost category of the under 65. Because of this, we could not enter into a pool with the under 65's. As we see the set-up, it would appear that the high-cost individuals would gravitate to P.S.I., purely because of experience-rating versus community rating, that we would then have a very large disproportionate share of those persons and it is our opinion that there should be some method worked out whereby these excess losses on the under 65's in the high-risk category, that P.S.I. or any community-rated plan would receive the credit for this extra cost.

Now, we have not yet been able to come up with all the details of just how you would arrive at this.

In general, I think we can say that you would have to take the indemnity experience-rated plans costs on the under 65's, which they have retained, not pooled, and compare this against the under 65's that they have pooled and, through mathematical formulæ, develop what ratio of those persons it would be assumed that a community-rated plan would have.

This would require a considerable amount of consideration to arrive at this. But we do feel very strongly that there should be some relief; otherwise, the community-

MR. LOWE: Yes. This is the problem that could identify the individual that would go in this high-cost age- a pool with the under 65's. As we see the set-up, it would appear that the high-cost individuals would gravitate to P.S.I., purely because of experience-rating versus community rating, that we would then have a very large disproportionate share of those persons and it is our opinion that there should be some method worked out whereby these excess losses on the under 65's in the high-risk category, that P.S.I. or any community-rated plan would receive the credit for this extra cost.

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rated plans would be picking up a very large share of that very high cost, which must be passed back to all the persons enrolled in its business.

DR. BUTT: I understand what you have said. Now, what I would like, for a little more clarification, is: You say there would be a percentage. Would you say that you have a higher percentage? In other words, I suppose you haven't got the answers in detail but I would be very interested to know exactly what you have in mind. Perhaps you can supplement this, if you feel so inclined.

MR. BOND: Yes.

DR. BUTT: I do not think it is elaborated sufficiently here for me to understand it. But I think we would be very interested in the details.

MR. BOND: This is an area that we feel would require quite a lengthy explanation.

DR. BUTT: You can probably send us this?

MR. BOND: As time goes on, we can certainly provide information of this nature.

DR. BUTT: Fine. Thank you.

DR. GALLOWAY: Do I take it then that you would be willing to enter into a pool if such an arrangement could be developed, or that you wish to just get credit for what the pool might be?

DR. BUTT: They haven't given an answer and

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DR. PRICE: I understand what you have said. Now, what I would like, for a little more clarification, is: You say there would be a percentage. Would you say that you have a higher percentage? In other words, I suppose you haven't got the answers in detail but I would be very interested to know exactly what you have in mind. Perhaps you can supplement this, if you feel so inclined.

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DR. [illegible]: They haven't given an answer and

they say they haven't got the actuarial figures.

MR. WHITNEY: You do not have the age distribution in the community plan?

DR. BUTT: They have the age and they are willing to pool over the 65. The under 65 provides high-risk in certain types of rather serious illnesses and I asked them how they could identify at the moment and they say they can't. What they say they were thinking of doing was take the percentage that the insurance companies have as high risks.

MR. WHITNEY: Thank you, Dr. Butt.

DR. BUTT: I believe this is correct?

MR. BOND: Yes.

MR. NAYLOR: Are you indicating that you might participate in the pooling for under age 65 risks if such an arrangement could be worked out?

DR. LOCKHART: We are suggesting that, yes.

DR. GALLOWAY: This is my question.

DR. BUTT: I am sorry.

DR. GALLOWAY: That is quite all right.

DR. BUTT: Now, there is another thing I was going to ask you about. You suggest somewhere that there be one open enrolment period. Is this correct -- just one for the whole thing?

DR. LOCKHART: Yes.

DR. BUTT: How do you feel we can get everybody

they say they haven't got the actuarial figures.

DR. WHITAKER: You do not have the age

DR. BUCK: They have the age and they are willing to pool over the 65. The under 65 provides high-risk in certain types of rather serious illnesses and I asked them how they could identify at the moment and they say they can't. What they say they were thinking of doing was take the percentage that the insurance companies have as high risks.

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covered, knowing the usual individual's lack of, shall I say they are unable to voluntarily accept all these plans immediately and I think probably would be more than one. I think it is in the interests of the coverage for the carriers to have everybody covered eventually.

DR. LOCKHART: We looked at the terms of the Bill and used an intensive open period at the beginning and there is provision that anyone can join at a later date, maybe with a deterrent or waiting period. So, we did not feel that probably an additional open period was necessary, that anyone could join at any time anyway.

DR. BUTT: With the deterrent?

DR. LOCKHART: Yes.

DR. BUTT: You feel that there should be a deterrent fee, though, if you do not join at the beginning?

DR. LOCKHART: A deterrent fee or a waiting period when benefits are not available for three months after joining, or some such technical detail.

DR. BUTT: It is either a financial outlay or a time prescription?

DR. LOCKHART: That is correct.

DR. BUTT: The Bill provides for one or the other?

DR. LOCKHART: Yes.

DR. BUTT: What about subsequent open

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DR. [illegible]: What about subsequent open

enrolment in a year's time, or two years time? There is a whole new group of people who have now come from age 19 to 21 where they would be on their own.

DR. LOCKHART: No. The provision in the Act, as I understand it, for this group of people as they reach the age of 19, they can automatically transfer.

DR. BUTT: Yes. They can automatically. But they have also set up a new way of life, and so on. In other words, they are probably independent in their own thinking. I am just trying to clarify whether you do not feel there should be certain open enrolments again?

DR. LOCKHART: I think the provision in the Act is that P.S.I. can determine open periods if required.

DR. BUTT: I am just asking for your opinion.

THE CHAIRMAN: May I follow that up? I understand that you do not think that is necessary and is the only reason that you do not think it is necessary because there is this provision in the draft now, whereby they may come in as they wish? Have you any other objection as to the group declaring another open period -- Medical Carriers?

DR. LOCKHART: I would say no.

THE CHAIRMAN: Thank you.

DR. BUTT: There is only one other thing. This 70% of the maximum premium -- is this what you feel should be the subsidy for the marginal income group, or is

enrollment in a year's time, or two years time? There is a whole new group of people who have now come from age 19 to 21 where they would be on their own.

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it 70% of the community-rated premium? If so, why?

DR. LOCKHART: I think we have said 70% of the maximum premium.

MR. BOND: Yes. We feel quite definitely 70% of the maximum premium, if you talk of 70% of the community-rated.

DR. BUTT: The community-rated premium is your term.

MR. BOND: First of all there is the community-rated premium. Secondly, this is just tying the subsidy to the rate set by an individual carrier, whereby we feel that it should be, if tied to anything, to a maximum rate set by all carriers.

DR. BUTT: More universal?

MR. BOND: Yes.

DR. BUTT: The maximum premium certainly isn't the one that you have in your policy. Even if it is a community-rated, is it not possible that somebody could be selling a policy less than 70% if it is a fixed dollar coverage? In other words, you can really buy your policy and pocket the difference?

DR. LOCKHART: It is theoretically possible and I think we would agree that if this occasion did come that it should be 70% or not more than the premium.

DR. BUTT: Fine, thank you very much. Those

it 70% of the community-rated premium? If so, why?

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MR. SCOTT: Yes. We feel quite definitely 70% of the maximum premium, if you talk of 70% of the community-

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MR. MACKAY: It is theoretically possible and I think we would agree that if this occasion did come

are all my questions.

DR. GALLOWAY: There must have been some considerable thinking go into this 70%. Can you give us the background of how you elected 70%?

MR. BOND: Basically, it was a matter of trying to select a figure which we felt would be reasonable, something which would be more than, say, half, in this category of their premium. 70%, we felt, from looking at various costs in different age groups, and so on, would be a reasonable sum. The balance remaining would not create a hardship to that individual to pick up this balance. This could be 65%; it could be 80%. A lot would depend on the maximum premium. We felt 70% was a reasonable figure. There were no great mathematical calculations.

MR. CASWELL: Your experience has, no doubt, suggested to you the problems that some individuals have of paying their insurance. You are suggesting that 70% of the premium be paid. Are ycu suggesting at what level of the income group level this be applied? I notice in your brief somewhere you are suggesting $7,000.00 income for an individual and $10,000.00 for a family. Are you suggesting that in this everyone below this income receive 70%?

DR. LOCKHART: No. This is not the case. That is a different item. The seven and ten are items that we have had in our contracts for several years. That allows the

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doctor to charge over and above the allotment of P.S.I. for individuals earning over $7,000.00, or a family income of over $10,000.00 and this is entirely separate from the premium subsidy of the partially subsidized group. This is based on the taxable income. On page 47 we have outlined recommendations which cover this area and that is that a subsidy be provided to those person whose personal exemptions are equal to or greater than their income. This, would be, gross income.

MR. CASWELL: I see.

MR. COULTER: Mr. Chairman, I would like to follow that up a little closer. On that particular point, supposing you over estimate my ability to pay then can you collect anything above the C.M.A. schedule of rates, supposing I refuse to pay this over billing because you have over estimated my ability to pay, that is $10,000.00 income.

DR. LOCKHART: This is probably a theoretical question and I think it would be solved quite easily between the patient and the doctor purely and simply explaining everything to the doctor. The doctor wouldn't charge over and above the ultimate of P.S.I. if the income was less.

MR. COULTER: I think a precedent has already been set, has this not happened before, where a person has been over billed without having the ability to actually pay it.

DR. STIVER: Yes, that has happened, Mr.

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Chairman, on occasion: Someone has appealed to us and we in turn write the doctor and sometimes we have given him a copy of the subscriber's letter or paraphrase it and ask the doctor to check again and talk to the subscriber. I can't think of an instance on the spur of the moment on which it hasn't been, under those conditions, settled to the satisfaction of all three parties. It is my view that the doctor can both over estimate and under estimate his patient's income.

MR. COULTER: That is the thing I am wondering about. Should the doctor ever be in the business actually of estimating my ability to pay.

DR. STIVER: Well, Mr. Chairman, it is the policy of organized medicine to recommend that the members of the medical profession talk quite openly and discuss openly their fees, and it just follows from that. It certainly hasn't been a problem in P.S.I.

MR. COULTER: If the case arose what recourse has the subscriber to having this clarified if he and the doctor can't agree.

DR. STIVER: Mr. Chairman, there was a case crossed my desk last week, and we simply asked the participating physician to make a refund. We have confirmation that he will do that. He over estimated or for some reason in his office he thought in this particular patient there was good reason for him to extra bill. The subsequent correspondence between

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the subscriber and his employer and P.S.I. -- we were able to point out to this physician we thought in this case he was in the wrong and the correct thing to do would be to make a refund and I hope that this is going to be done within the next few days.

THE CHAIRMAN: Will employers release that information to you, the wages paid to the employee?

DR. STIVER: We have never been placed in the position of asking an employer. We ask the employer to have the patient familiar and surely the patient must know what he gets. I can't recall a case in which we have asked the employer.

THE CHAIRMAN: Your contract with the individual physician requires him to set his income?

DR. STIVER: Not to us. We have taken the attitude, Mr. Chairman, it must be income -- that is the problem, and we know it is the problem between the medical profession and the patient, between the individual physician and the patient and errors are made because unless the patient brings him his last income tax return the doctor must judge by all sorts of factors as to the income bracket the patient is in and errors do occur.

MR. CASWELL: Mr. Chairman is this a suggestion the medical profession feels because a person's income is above a certain level he should pay more money than the

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DR. SCLYER: We have never been placed in the position of asking an employer. We ask the employer to have the patient familiar and surely the patient must know what he gets. I can't recall a case in which we have asked the employer.

THE CHAIRMAN: Your contract with the individual physician requires him to set his income?

DR. SCLYER: Not to us. We have taken the attitude, Mr. Chairman, it must be income -- that is the problem, and we know it is the problem between the medical profession and the patient, between the individual physician and the patient and errors are made because unless the patient brings him his last income tax return the doctor must judge by all sorts of factors as to the income bracket the patient is in and errors do occur.

DR. OASNER: Mr. Chairman is this a suggestion

individual who receives less?

DR. STIVER: No, I don't think that is the true inference, Mr. Caswell. I think in these cases the medical profession, the individual physician feels that the demands possibly, and this is an adjective we don't like, but I think you will understand, are luxurycare -- I think there is always that factor. There is the demand for extra care or very close care in which the physician in that particular case feels that he is justified in an extra account. I think there are two factors in all the cases I have seen and had to administer. It is not just purely income. I don't think that is a fair inference against the medical profession.

MR. CASWELL: I am quite concerned, and perhaps I misinterpreted the information here in the brief which I highly respect because of the respect P.S.I. is held in. It seems to me unless I am wrong you are contradicting yourself to the degree you emphasized the fact that you don't believe the Act should have a standard medical plan, standard in hospital plan and that the standard in hospital plan should be deleted. I might say I thoroughly agree as an individual with you. You go on to say over several years there could be one large medical plan one which is an in hospital plan and one which is a para medical plan which appeals to me greatly. Is it because of your experience in having three plans that you feel there should only be one.

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individual should only be one.

DR. LOCKHART: Dr. Stiver, please.

DR. STIVER: We realize, Mr. Chairman, you may read in our submission a contradictory viewpoint. Our Board brought out a limited plan eight or ten years ago because at that time we thought, and of course opinions and decisions may change, Mr. Caswell, but we thought possibly there was more demand for it. There was a lot of consideration of how P.S.I. got a limited plan. We didn't take it out of the blue. I don't think it is necessary to go into it. Some practical information might be of interest to you. Since that time our enrolment in our limited plans has greatly gone down and groups have changed over to the comprehensive care. All things being equal we can visualize that our Brown plan could disappear within the next three or five years if this trend continues. Possibly it may be sooner. I think if we were in the position where there were only just a few we would just wipe it all out a certain date.

MR. CASWELL: Do I take it they are transferring from the medical plan to the extended health plan.

DR. STIVER: No, they are transferring to the comprehensive plan, sir.

MR. CASWELL: Is your experience with paramedical and in many submissions that have been made to us, and frankly I think this is what is concerning us, the more submissions we listen to the more we have come to realize that

MR. SILVER: We realize, Mr. Chairman, you may read in our submission a contradictory viewpoint. Our Board brought out a limited plan eight or ten years ago because at that time we thought, and of course opinions and decisions may change, Mr. Cosgrove, but we thought possibly there was more demand for it. There was a lot of consideration of how P.S.I. got a limited plan. We didn't take it out of the blue. I don't think it is necessary to go into it. Some practical information might be of interest to you. Since that time our enrolment in our limited plans has greatly gone down and groups have changed over to the comprehensive care. All things being equal we can visualize that our Brown plan could disappear within the next three or five years if this trend continues. Possibly it may be sooner. I think if we were in the position where there were only just a few we would just wipe it all out a certain date.

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just giving physicians' services alone doesn't seem to be sufficient for the health of the nation. You para-medical plan is a step in more inclusive or all inclusive services. What has been your experience with that.

DR. LOCKHART: We have Mr. Williams who is familiar with that.

MR. WILLIAMS: I didn't quite get the question.

MR. CASWELL: You have what you call a para-medical plan. Has your experience with that been good enough that you would suggest or recommend this might be a pattern for Bill 163 to follow?

MR. WILLIAMS: I said, first of all, I don't believe, Mr. Caswell, it is our most extensive plan. Our blue plan that is described in here, our blue plan covers medical care and is the most extensive. Our para-medical plan covers the services the doctor needed to take care of these patients. Our experience with the plan has been very good.

MR. CASWELL: You are suggesting on the doctors order there would be nursing services, prescribed drugs, medicines, ambulance services, physio-therapy, appliances -- this is certainly getting considerably beyond what Bill 163 has now. This is certainly along the line of what many of the submissions have been made to us said, that people need more than just what Bill 163 is giving them. That

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THE CHAIRMAN: Are your comparative rates for these plans in the brief?

MR. WILLIAMS: Yes.

MR. WHITNEY: The services under your para-medical plan are services only ordered by the doctor, are they not?

MR. WILLIAMS: Yes.

MR. WHITNEY: There are no free services under them?

DR. STIVER: There is the point of control.

MR. WHITNEY: Your para-medical services must be prescribed and ordered by a physician or surgeon.

DR. STIVER: Yes.

MR. CASWELL: It is a step forward from Bill 163.

MR. WHITNEY: You are quite right.

MR. LOCKHART: Could I clarify one point. We are making no recommendations re Bill 163 as far as para-medical services are concerned. We have included this in the first part of our brief which is the explanatory section purely and

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simply explaining what we now have. We are making no implications regarding the implimentation of para-medical services.

MR. CASWELL: What I was trying to arrive at, Doctor, we know the need is there. The problem devolves how extensive should this be, can we afford to include these services and if we can should we not do so. With the experience P.S.I. has you have a pretty good idea whether this is a costly service, a service that is very costly and could it be included or should it be included. That is what we are trying to get some information on from the experience that P.S.I. has had. Could you say it isn't unreasonable to include it in Bill 163?

DR. BUTT: Perhaps I could clarify this. It is on an indemnity basis and kept separate from your so-called blue or comprehensive plan. Perhaps this would clarify exactly what is meant. The other plans that have been proposed are not on an indemnity term at all. It is total coverage. Perhaps you could explain this in detail.

MR. WILLIAMS: Mr. Butt, could I have your question again. I heard it but I didn't quite follow it.

DR. BUTT: Extended health benefits are not the same as your Blue Cross or your blue plan.

MR. WILLIAMS: No, that is right.

DR. BUTT: In the way it is operated. I think if you could give details that would help us.

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MR. WILLIAMS: Our blue plan is designed to cover the services of physicians only and as this plan developed we realized there were other things where it was possible to have it covered by premium of this type as medicare has here, some of these things were drugs and dressings and medicine and plaster casts and so on. That is how we developed our extended health benefit program. As Dr. Lockhart pointed out we are not recommending it to the Committee because it is now outside of the Act as we see it.

MR. CASWELL: It is not outside of the Act. It is up to this Committee to recommend to the Government what ought to be in the Act. That is why we were appointed. I don't think anyone should have the impression this Act has been handed to us on a platter and has to be accepted. If that were the case we ought to not be here.

MR. WILLIAMS: There is one other point I wanted to make here: Our blue plan or brown plan, they are total coverage. We have no deductions. Our extended health benefits and this service plan are extended health benefit plans as compared with indemnity plans and have $50.00 deductible. There is a definite difference in the operation of these two programs.

MR. CASWELL: I can quite appreciate that but even so it has been economically sound for you to operate on those terms, I assume, as it has been growing in popularity.

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MR. CASWELL: I notice that you suggest it has been brought about largely because of demand from the public.

MR. WILLIAMS: I don't think anyone in the business would deny this type of program has a great deal of popularity over the last five, six, seven years.

MR. CASWELL: Dr. Lockhart, you have suggested in here and I think rightly so that to date the para-medical members have been working pretty well with welfare cases and the Government. This is covered in Schedule C. It seems to me you are suggesting this should continue in this manner and therefore be left out of Bill 163, that the contract should be between the para-medical profession and the welfare plans and Government and should not belong to Bill 163.

DR. LOCKHART: Yes.

MR. CASWELL: This would mean that the Government shouldn't be buying this service from carriers in general, it would be allocated to just one group; is that not right?

DR. LOCKHART: We are suggesting since the medical welfare have handled this for years and have done, I think, an adequate job that they might be well advised and be able to continue the proper coverage for these people. However we do say that if this is not within the desires and intentions

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of the Government, we go on to say we would be prepared to take a look at it and see if we couldn't assist Government in providing coverage for these people.

MR. CASWELL: It would seem to me this is perhaps among the high cost coverage items. I may be wrong.

DR. LOCKHART: I wouldn't be able to answer that.

THE CHAIRMAN: Not necessarily. I don't see any reason why it would be necessary.

MR. CASWELL: One other question: You have made a recommendation to the Enquiry relative to the Board of Directors of the Medical Carriers Incorporated. You have seven persons, two representing the P.S.I., one Windsor Medical, two the carriers, and one representing the carriers in general. We have had several submissions made to us suggesting that the subscriber ought to have representation on the Medical Carriers Incorporated, that he had direct interest, that he is the man that is buying medical coverage. Does P.S.I. feel that this isn't necessary, that the subscribers' opinions should not be voiced with the medical carriers?

DR. LOCKHART: On this level, yes. We feel as we understand it this would be purely and simply be an administrative body having to do with the operations of the carriers, and not the proper place, probably, for consumer representation.

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DR. LOCKHART: The Medical Carriers, the rates would depend upon the benefits and if there is a place for consumer representation it would be at the level, I would think, where these various benefits are discussed and arrived at rather than at the level of direct administration.

MR. CASWELL: I am not going to argue this with you. I certainly got your opinion anyway and that is what I wanted.

MR. MAJOR: Mr. Chairman, I don't think it should be left there because we in this Enquiry have read several briefs which do answer this question to some extent. In other words I think what the P.S.I. delegation are saying now is they are only interested in the technical aspects of this Bill and they are not being presumptuous enough to get into the policy of that Bill which they feel is outside their field. We know on this Committee that the recommendations have been and will be made that a policy body be set up. If this

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THE CHAIRMAN: They are not recommending that. That is not included in your recommendations and it is not suggested in the draft of the Act itself.

MR. MAJOR: That is true.

MR. CASWELL: That is all.

THE CHAIRMAN : Mr. Naylor.

MR. NAYLOR: Your recommendation that Schedule B be deleted, in hospital and medical plans has been referred to a couple of times already. I would like to ask a further question about it. One of the reasons you give for this recommendation was that this plan put the pressure on hospital facilities. It would, of course, be possible to have a standard plan which wouldn't be based on hospital implementation, for example, they might have a deductible co-insurance. Would you still feel the same way about that restrictive type of plan, in

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other words do you feel that there should only be one plan, a first dollar plan or do you think it would be helpful to have an alternate plan at lower premiums?

DR. LOCKHART: Mr. Chairman, as far as we are concerned in the operation of our service plan, we could not work on our present way of doing business with a deductible and co-insurance in our service principle.

However, we see no reasons why those carriers whose operations are such that this could be built into their plan couldn't provide the same benefits as the standard service contract, that is the standard coverage with built-in deductibles or co-insurance.

MR. NAYLOR: Yes, I think that answers the question. Actually it would be recognized that a service type of plan such as yours should be required to issue a plan of this kind. It would be just an optional alternative.

MR. WHITNEY: Mr. Naylor, shouldn't you ask -- that was a statement of conclusions to you, the answer. I still don't understand why you couldn't have alternate plans.

DR. LOCKHART: In our service contract?

MR. WHITNEY: No. Why you couldn't still have your regular P.S.I., and then if the Bill requires every carrier to have it available, to have the standard contract available.

DR. GALLOWAY: They said they couldn't operate with co-insurance---

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DR. LOCKHART: Under our type of business, in handling the standard contract we would find it very difficult, if not impossible, to work with a deductible and a co-insurance, having the standard plan on our principle.

MR. WHITNEY: Why? That's what I wanted to get at.

THE CHAIRMAN: I think that what Mr. Whitney is looking for here is that when you say type of operation, what do you mean by type?

MR. WHITNEY: What do you mean when you say you would find it very difficult? Would you enlarge on that, and tell us why you couldn't do so?

DR. STIVER: Well Mr. Chairman, we don't see how that could be written into a participating physicians' agreement on this service principle. I don't know how we would handle the deductible, and the participating physicians' agreement, in which we have deeply obligated ourselves to pay directly to that participating physician.

MR. WHITNEY: I know there is difficulties here. That's what I'm trying to find out.

DR. STIVER: Let's assume, Mr. Chairman, that the deductible is $25.00. Now, which doctor's account do you take the $25.00 off? If you arbitrarily said the first account that comes into your office, that might be most difficult, and very unfair to the subscriber and that doctor.

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If you were to say it will be the first doctor that sees any individual in a certain illness, that administratively is very difficult, because it may be only a part of the first doctor's bill. The general physician sees the patient in the home for $5.00, and we can't get $25.00 deductible off that, and the very next bill is major surgery, at $250.00.

Do I make my point, sir?

MR. WHITNEY: Yes, I think that's part of the thinking. I don't think we have a solution though.

DR. STIVER: I don't see how we could handle the patients on first dollar coverage paying participating physicians and the deductible period.

MR. WHITNEY: In other words, if you stay with the physician participating, other types of contracts would be incompatible?

MR. NAYLOR: Yes, another recommendation you make is that not only should recognition be given through your pro-rated basis of payment to participating physicians, but also that you should be permitted to pay the same percentage of the schedule to non-participating physicians, where those are used by your subscribers.

I have two questions about that. First, do you feel that it would be possible to justify permitting one carrier to pay on a basis lower than the full schedule to physicians with whom they don't have an agreement, and not

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extend the same arrangements to other carriers?

DR. LOCKHART: I don't see how your -- I think experience -- the only answer I can give you is our experience of 15 years has made this a reasonable way of our carrying on.

The one thing is that to the non-participating physician we remunerate the patient, not the doctor. It's only to the participating physician that we have the contract where the physician does accept the responsibility of the underwriting principles, accepting our payment as payment in full, and the doctor accepts that responsibility that we make this payment, and we feel it would undermine the whole principle of the service concept if it were really, this principle was removed, and we would have to pay the non-participating physician more for the services than we paid the physicians who are accepting the responsibility for making the service principle work.

Therefore we have recommended that we should not have to pay on behalf of the services rendered by a non-participating physician to a subscriber any more than we would pay to a participating physician.

MR. NAYLOR: There's another problem about that too that I would like to ask you about.

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MR. MAYNOR: There's another problem about that too that I would like to ask you about.

The Government, presumably, would like this plan to be a comprehensive one, particularly for the persons

in the lower income groups, who need assistance in paying the premiums. That is those who might be subsidized under this arrangement.

Do you think that it would be consistent with that idea that under some circumstances these persons wouldn't have their full bill paid, and if such a person went to a non-participating physician, do you think that physician would accept the lower base of payment in full, or have you any thoughts on this problem?

DR. STIVER: Well Mr. Chairman, in our experience we have, I suppose, thousands of families who according to our records have received all their medical care from non-participating physicians and seem to be perfectly happy with the care they get, and with what the P.S.I. can give them in reimbursement, which is the same amount as we would pay participating physicians.

MR. NAYLOR: Well, do they not have to pay the difference?

DR. STIVER: We don't know that. We look upon the service of a non-participating physician as the private practice of medicine.

We do know that some families, I presume because they haven't got the ready cash, wait for our payment, and whether they put it in their bank account and write a personal cheque for the same amount, we don't know. I suppose

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it's reasonable to say that probably in some cases a non-participating physician is taking our cheque only, but we don't know that the subscriber hasn't handed another $15.00 in cash, or his personal cheque, along with ours.

Strictly speaking, the day to day administration is really none of our business.

MR. NAYLOR: You point out in your brief that the great majority of your claims are with participating physicians, so is it true that if it were not considered satisfactory to have this arrangement for non-participating physicians, that the financial effect on you would not be too serious?

DR. STIVER: I don't think our recommendations, if I may answer that Mr. Chairman, they are nothing to do with finances. It's the principle.

DR. BUTT: Would there be a great deal of difference in saying that this was 10% pro-insurance, if the whole thing was on an indemnity basis, with a co-insurance factor?

DR. STIVER: We would not like to construe our thinking on this.

DR. BUTT: You feel that this would be muddying the waters even if it were technically the same thing? In other words, the individual could or could not collect the 10% as a co-insurance for the doctor?

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DR. STIVER: No, I wouldn't like that one.

DR. BUTT: You wouldn't like to have it phrased that way?

DR. STIVER: No.

MR. MULROONEY: On page 44, at paragraph 108, the brief states: "If some provision of this type is not implemented permitting the "service carrier" to pay less than the approved schedule regarding the services of non-participating physicians then the "service carrier" must re-assess its position."

Would you like to amplify this statement, and tell us what you mean by it?

MR. BOND: We mean by this, Mr. Chairman, that if it was possible to carry out the service principle on the basis that we now know it, that we would have to take a long look at our approach to medical care, and determine whether or not in the light of the Act and the standard plan, whether we should, for instance, change this standard plan over to an indemnity basis, rather than a service approach to the plan.

This is basically what we mean by assessing this, owing to the fact that it would have non-participating physicians.

MR. MULROONEY: Have you calculated what your additional premium would have to be if you were required

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MR. MURROONEY: Have you calculated what your additional premium would have to be if you were required

to pay 100% of the O.M.A. schedule?

DR. LOCKHART: Mr. Chairman, no, we haven't considered this at all. We feel, first of all, that we are not pressing this point on the question of dollars and cents, but we are, as Mr. Bond stated, on the question of principle, and that we have had 15 years of the service principle in P.S.I. Some other carriers on the service principle have had longer, and experience has shown that as far as we are concerned it's been successful. It has proven itself in the Windsor Medical and P.S.I., and we feel that if the service approach is desired in the standard plans then we should have some of these conditions to make this principle work.

Our alternative, as Mr. Bond suggested, is that if this principle isn't desired, the service principle to be maintained, then we may well have to alter our whole concept, and revert to an indemnity type of program, and we feel that the experience of the last 15 years certainly shows that the population of this Province like the service approach, and we feel that we would like to see it continued.

MR. WHITNEY: Going further on that point, do you feel it destroys the service principle if you pay a 100% to the doctor, instead of 90%? Is the amount of the payment basically essential in what you call the service principle?

DR. LOCKHART: Partly, but more than that is the physicians accepting the responsibility in the service plan,

to pay 100% of the O.M.A. schedule?

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and in accepting the responsibility of the underwriting features, and the participating physician's association.

This is inherent in the service plan.

MR. WHITNEY: You mean accepting the 10% cut in their fees, and paying the administration?

DR. LOCKHART: It's not just a 10% cutting of fees, and the method of arriving at 10% is delineated in our physicians' contract, and in essence the principle is that the services rendered, and the premiums, shall be based on a 100% of the tariff of the O.M.A. in our particular case, and basing a premium on a 100% payment. The premium is collected, then the doctors accept the responsibility for the operating expense, and a small amount to the contingency reserve, and what's left is paid to the physician, and this gives the doctor the responsibility of operating the plan, because he's accepted the responsibility for paying for its operation.

THE CHAIRMAN: That principle was not followed out, though, in 1962, in that particular year?

DR. LOCKHART: No.

THE CHAIRMAN: In other words, you still paid 90% of the doctors' bills, even though you operated at a substantial deficit?

DR. LOCKHART: This is correct.

MR. MAJOR: Mr. Chairman, that was only so because the technical operation of the plan makes it necessary

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to set up reserves to protect both the subscriber to the plan and the physician.

This is set forth in the participating physician's agreement. If you will refer to it, you will find that this is an obligation, that the participating physician must see to it that his plan must do this.

THE CHAIRMAN: This is correct, and I assume then that if you continued to drop down three million a year, you would soon then either have to increase the rates, or apply your principle?

MR. MAJOR: That's right.

MR. COULTER: Mr. Chairman, may I follow this a little further? It's assumed that public money will be in this Bill, or whatever is instituted, and by the participating doctors accepting from P.S.I. and W.M.S. 90% of the fees, does this not put them at a distinct advantage over other carriers, who have to pay a 100%, and how can you justify the Government having to pay 90% to some carriers and a 100% to others, from public funds?

MR. CASWELL: Mr. Chairman, as I understand it, the Government would pay a 100%, that they would bill their regular fee, or whatever fee is agreed upon.

MR. SIMON: As long as they aren't paying more than 100%, the Government should be satisfied.

THE CHAIRMAN: There's not any suggestion of

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MR. COULTER: This is true. P.S.I. doctors agree to take 90%, but other carriers in the same operation are forced to pay 100%.

This is the point I am getting at, because there will be public monies in both bills.

MR. MAJOR: The doctors are not bound to take the payment as full and final. You are basing your presumption here on the basis that you can regulate the private personal fee for the profession, but this is not true. The only way that you can regulate the fees of the profession is to put the profession under a legal contract.

Now, we must assume that there are no contracts between the people that you are referring to and the profession; therefore, there is no guarantee that the 100% payment set forth under Bill 163 is the full and final payment, and this makes a world of difference.

MR. COULTER: Probably I am not explaining myself right here. Other carriers, other than P.S.I. or W.M.S. are usually billed -- and you can correct me if I am wrong, because I have no axe to grind here -- but are these other carriers billed, ordinarily, at 100% of the O.M.A. schedule of fees?

MR. MAJOR: No, sir. The carrier is not billed; the citizen is.

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MR. MAJOR: No, sir. The carrier is not billed the citizen is.

MR. COULTER: The carrier subscriber is billed?

MR. MAJOR: That is correct.

MR. COULTER: Under W.M.S. and P.S.I., the subscriber is billed for only 90% of this fee?

MR. CASWELL: No. They are billed for 100%. P.S.I. gets 10% of that.

MR. WHITNEY: Mr. Naylor, Section 17 of the Bill refers to the O.M.A. schedule. How does that fit in with the remark you made a moment ago?

THE CHAIRMAN: You are addressing that to Mr. Naylor?

MR. WHITNEY: I was not sure what he said a moment ago about no guarantee under the Bill that benefits would be paid at 100% of the O.M.A. schedule.

THE CHAIRMAN: You mean Mr. Major?

MR. WHITNEY: Yes, I am sorry. I mean Mr. Major.

MR. MAJOR: I am sorry, I wasn't paying any attention.

MR. WHITNEY: I thought a moment ago I understood you to say that there is no guarantee in the Bill, or provision in the Bill, to assure us that the benefits would be on the O.M.A. schedule.

MR. MAJOR: No. I said there was no guarantee

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MR. WHITNEY: You mean the doctor can bill the individual patient over and above the O.M.A. schedule and only the O.M.A. schedule amount would be the benefit under the standard contract?

MR. MAJOR: That is correct.

MR. WHITNEY: So there could be extra billing. There is no protection against it?

MR. MAJOR: That is correct.

THE CHAIRMAN: Mr. Naylor, would you like to carry on?

MR. NAYLOR: Yes, Mr. Chairman. On page 45 of your brief, there is a recommendation that one clause in the Bill be eliminated. This is a clause which provides for "'limited and incidental insurance against medical and surgical expenses provided in conjunction with motor vehicle liability, employers' liability, public liability and workmen's compensation insurance policies' should be relieved of the obligations of carriers of 'medical services insurance'". And you suggest this might set up an area of discrimination. I just would like to comment a little on that and then ask you

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if you still think that this should be eliminated. There is no intention to have any discrimination, but only to be fair to certain carriers. For example, there are some companies that might have policies that include some benefits for medical and surgical expense, under certain circumstances, accidents or something, for which a premium would be very small and the same carriers might have a non-cancellable policy under which rates could not be changed, and so on.

With such a low premium for the very small benefit provided for medical and surgical expenses, they feel that it wouldn't be fair to ask them to carry, in respect of these policies, any part of the cost of the pooling arrangements. That is, I think, the reason for this clause, and it does seem to me, personally, that that is a reasonable thing to do.

In the light of those comments, do you still think that there is anything wrong with this clause?

DR. LOCKHART: Yes. I think we have discussed this and we feel that this is a reasonable recommendation. I would ask Mr. Bond to enlarge.

MR. BOND: Thank you. If the worry is anticipating a pool, if there is one, would it not be better that the exemption be granted from the pooling, if this is their worry.

MR. NAYLOR: I think that is the main thing.

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MR. BOND: We feel that it could be a loophole in this Bill for the carrier who wanted to take advantage of it. This is the point we are making and to eliminate this, we feel you will eliminate this type of coverage.

MR. NAYLOR: Yes. I think you have clarified it. I think the main concern of such companies would be that they wouldn't have enough premium for this very limited form of insurance to carry pool losses and you have indicated that perhaps they could be exempt from that. Just one other point. On page 49, I think it is, you suggest that the administrative costs of operating Medical Carriers Incorporated should be borne equally by all its licenced members. I take it from that that you mean that the share assessed against P.S.I. and every other carrier should be equal? As you have indicated in your brief, you are the largest carrier in the Province and this is the largest premium for medical insurance. Is this a fair arrangement, to allocate the administrative costs equally, or shouldn't it bear some relationship to the premium income or the number of lives insured with the different carriers?

MR. BOND: Mr. Naylor, our feeling on this is that the amount of work involved for M.C.I. in the administration would not vary in accordance with the number of persons enrolled. M.C.I. is setting regulations and the regulations apply whether a carrier has 10 persons or 100,000 persons covered. The work, as we see it, would be equally spread

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amongst all carriers, that this would bear no relationship to the number of persons covered and, therefore, we feel that the cost of this administration should be borne equally by all the carriers.

MR. SIMON: It reminds me of the chicken and the elephant -- they are both equal.

On page 1, Dr. Lockhart, of your brief I was quite interested in reading about the structure of your organization.

In paragraph 3 you speak about the House and then you say "The Board of Governors of P.S.I. may appoint interested laymen to the House." Can you tell us who those laymen would be? Would they be some of your subscribers? Are there any laymen on any of the set-ups of the P.S.I. organization?

DR. LOCKHART: We have two laymen on the Board at the present moment, who are sitting there because of their not representing anyone, but rather because of their business advice that they have, that can be utilized by our Board.

This is the aim that we have, with non-medical men on the Board, we hope will sit there to provide administrative business advice to our Board.

MR. SIMON: For your information, some of the Union members that we have already had before us, complained

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On page 9, paragraph 43, you suggest that a person may leave a group and then pick up his subscription. Will he pick it up at the same rate?

DR. LOCKHART: There is a small increase, a carrying charge, to take care of the administrative detail, really, in servicing an individual in modifications of premiums and payments, in contrast to not very much more cost for taking the payments from a complete group. So there is a small additional charge. The pay-direct charges are listed in the tables.

MR. SIMON: On the same page, in paragraph 46 and paragraph 47, you speak about community enrolment. I would like to know your experience in that? Has it been successful and do these community groups also come in in the normal group rating?

DR. LOCKHART: I would like to have our enrolment manager answer that because he has been in charge of our enrolment.

MR. WILLIAMS: What we do in our community enrolment, rather than taking a payroll as our breakdown, for the underwriters, we take the geographical location , rather than charge our group rates, because we can find no method of

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collecting those rates in a bunch and the only fair thing to do was to offer those people our regular pay-direct rates. It would be the same as somebody would pay if they left a group and went on pay-direct because we bill those people pay-direct.

MR. SIMON: They are slightly higher than the normal.

MR. WILLIAMS: Yes; but the same as our pay-direct rates at the moment.

MR. CASWELL: In any community you would go into, they would be the same?

MR. WILLIAMS: That is right.

MR. SIMON: On page 11, paragraph 56, you speak about the need to subsidize unemployed. You say "...it would be gratifying if these needy people could find some financial assistance." Have you any suggestions in this regard?

DR. LOCKHART: Mr. Chairman, I think if we could read the context of Bill 163, that there will be provision for the partial subsidy.

MR. SIMON: You specifically speak about the unemployed here. How long does a person have to be unemployed to be eligible to apply for a subsidy? I thought you would have some ideas on that.

DR. LOCKHART: No. We have not worked out

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DR. LOCKHART: No. We have not worked out

the details. We think this is a detail that can easily be developed, probably, by one of the functions of M.C.I.

MR. SIMON: On page 12, paragraph 60, you say "...it is quite conceivable that coverage by voluntary agencies, including P.S.I., could eventually be made available to any individual who could afford to pay for it -- regardless of age or condition." Bill 163 makes this already mandatory.

DR. LOCKHART: That is right. This is in the first part of our brief. It really is an explanation of our present way of doing business and this is purely and simply an additive explanation of our community enrolment; given time, even without the Bill, that in our progression in community enrolment, that this could have happened.

THE CHAIRMAN: May I pursue that, Mr. Simon?

MR. SIMON: Yes, Mr. Chairman.

THE CHAIRMAN: You do have different rates, though, on an individual basis for people according to their age, don't you?

DR. LOCKHART: No. Our community enrolment, which probably would exemplify this more than anything is, in essence, a pay-direct rate which is available to anyone in the community, regardless of medical condition and age, at a uniform rate, providing the same benefits to all of these people as available in our comprehensive plan, for a standard rate.

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THE CHAIRMAN: You are talking about the geographical community here?

DR. LOCKHART: That is right.

THE CHAIRMAN: Thank you.

MR. SIMON: In the previous paragraph you speak about 60% of enrolment in certain communities, although the overall enrolment in P.S.I. is about 27% of the population?

DR. LOCKHART: That is correct.

MR. SIMON: In other words, you find that if you go in and do an organizing job, if I may use the Union term, in a community, you can succeed in bringing the percentage up to 60?

DR. LOCKHART: This has been our relative experience to date, yes.

DR. STIVER: That includes the group that we already have enrolled -- not just community enrolment.

MR. SIMON: Yes. You say that other people are just negligent, are gambling on their health; otherwise they, too, could probably come in?

DR. LOCKHART: There is no doubt there are some of those people.

MR. SIMON: What about those who just can't afford it?

DR. LOCKHART: This is one of our worries, as we have said.

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MR. CASWELL: May I just make a comment here. As I understand it now, an individual cannot apply and be accepted on a pay-direct P.S.I. group in an area where you are not in?

DR. LOCKHART: At the moment, on our comprehensive plan that is true.

MR. CASWELL: But you are suggesting that as far as the Bill is concerned, you are quite ready to open this up. It interested me. You have one rate that applies to all age groups, regardless of health conditions because this is, again, one of our big problems and this is one of the items that came out recently in the press and caused much concern to a lot of people. That is that there would be a higher rate for persons over 65, and this is not necessarily so. But your experience, I take it, has been reasonably satisfactory with giving a rate to people of all ages?

DR. LOCKHART: Yes. Mr. Bond, would you like to comment on that?

MR. BOND: Yes, Mr. Chairman, Mr. Caswell. For the past 16 years we have been, in essence, carrying out a pooling arrangement with this community-rated approach and this allows you to take the high-cost persons, the age that we all know statistically in the average there are possibly more than the younger person, and apply the same rate throughout. This is one of the features of the community-rated approach.

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MR. SIMON: But you have suggested here that according to the population figures, the over-age 65 is decreasing, ,not increasing as the increase in population. There are about 8% now of the population and you are suggesting that this is going down?

MR. BOND: Would you point that part out? I do not recall that.

MR. CASWELL: At the bottom of the page.

MR. MAJOR: Page 34, I think it is.

MR. CASWELL: Yes. It says "The 65 years of age and over group represents 8.2% of the total population of Ontario. However, according to population projections made by the Ontario Department of Economics, the number of older persons is expected, in the next 20 years to constitute a slightly smaller proportion of the total than it does now."

MR. BOND: Yes, this is quite true.

MR. CASWELL: So this should be even easier to include in one rate in the future?

MR. BOND: I would think so, yes.

MR. CASWELL: Thank you.

MR. SIMON: On page 28 of your brief, you cite the subscription rates going back to 1948 and I notice that the subscription, the rate for a subscriber and more than one dependent has increased from $5.00 per month to $10.75, which is approximately 118%.

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MR. SIMON: On page 28 of your brief, you cite the subscription rates going back to 1948 and I notice that the subscription, the rate for a subscriber and more than one dependent has increased from $5.00 per month to $10.75, which is approximately 115%.

The cost of living certainly hasn't gone up that much. If my memory is correct it has gone up since 1939 thirty-four points. Wages and salaries have gone up a little higher, possibly 80% or so. What has prompted this high increase, is that the higher utilization of health services? What made P.S.I., would force P.S.I. to go that high.

DR. LOCKHART: I think there are many factors of it working in the last 15 years that makes this apparent discrepancy show up. I think probably Dr. Stiver could clarify this from his point of view.

DR. STIVER: Mr. Chairman, I would think there are three main factors here. Since 1948, 1951 to 1963 we have made our comprehensive plans, our blue plan appreciably more comprehensive; in other words we have increased benefits to the consumer. The second factor has been the gradual increase of the O.M.A. schedule fees. I think it is only fair to state that the fee schedule for the O.M.A. it is only probably within the last three to five years that the fee schedule has caught up with itself. In other words I think the first fee schedule that I saw was 1936 and it wasn't a realistic schedule even for that time. I won't speak here for the O.M.A. This question could be asked tomorrow, whether there was inertia, or good reasons to keep the schedule beyond what was actually happening in the Province in certain years. I don't know whether this is good policy. I think we

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all agree that the schedule fee lagged behind. The O.M.A. in its wisdom, I would say from about 1952 onwards tried to improve that schedule or make it a more realistic schedule. They improved it. They enlarged it. The schedule has been a factor there.

I think the third is probably a continuation of utilization. I think we rather pride ourselves our subscribers in the blue plan are gettinggood medical care. They are getting medical care when they think they need it. That is an entirely different concept, when the public thinks they need it and when the profession thinks they need it. There is a reflection here too, Mr. Simon, what P.S.I. has done on an experimental basis in many aspects during the last fifteen years, portability, pension group and last but not least is community enrolment. I think these three or four factors are all reflected in the rate structure of P.S.I. from 1940 to 1963.

MR. MAJOR: I could add one thing to that that is rather unique. Whether this would show up in the indemnity insurance companies or not I don't know. It so happens that the utilization of medical care follows the increase in the gross national product very closely in the area. I think you would find this to be so throughout the North American continent where service plans are in operation. You have this statistical factor of somewhere between three and three-quarters to four and three-quarter increase per annum.

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We all heard a lot of talk about over utilization. This isn't definable. We think now we are coming to the stage where utilization is possibly where it should be. The people are getting the services that they require. Whether or not this will fall off we can't determine. This Enquiry may be well advised to investigate statements made by Dr. Ni Sinai and Dr. Q.J. Axelrod of the University of Michigan where they have been attempting to estimate growth line of utilization and service work. This has been a very commendable project, but I am afraid they haven't got the answer. An inflationary aspect in service work is very comparable and much the same trend line as the national gross product.

MR. SIMON: At page 38, and I believe the question has already been asked and you have taken the position that there should be elimination of "standard in hospital medical services insurance contract". That is paragraph 92. What happens to the 250,000 subscribers that carry this plan?

DR. LOCKHART: We have indicated that as far as we are concerned if it were required we would continue to offer the in hospital plan only even if our experience has shown that it is not a plan that the majority of people desire. It is not a plan that has built into it the things which we feel are optimum in a Government approved, shall we say, plan. We are prepared to continue but if our growth line in this

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particular plan means anything it indicates that the desire of people to have this coverage is less and less. In spite of our enrolment department continuing to sell the brown plan we are losing in numbers in the brown plan and they are going to our blue plan because of the transfer of groups where they have found advantages and the blue plan is available to them. They are transferring to the blue plan from the brown plan. We feel this will likely, if allowed to continue on, sooner or later solve itself because the brown plan will not sell.

MR. SIMON: Is that what you mean on page 59 in paragraph 97 there only be one standard plan and carriers be allowed to sell insurance lower or higher.

DR. LOCKHART: That is right.

MR. SIMON: That is not what is anticipated in Bill 163, lower standards or higher.

THE CHAIRMAN: My interpretation of this, and I don't say it is final, but my interpretation of this is that it means a standard plan available to everyone at not more than a maximum price, but that individual carriers can make less than the standard plan; can make: (a) the standard plan available at not more than a maximum price and (b), can make less than the standard plan available at less than the standard price while they also have to make the established minimum plan available at not more than the maximum price.

MR. SIMON: There you have no control of

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rates as far as the service.

THE CHAIRMAN: They can go down as far as they want with any type of plan they want. They have to have the minimum plan available at not more than the maximum price. That is my interpretation of this.

DR. GALLOWAY: I wonder if I could bring up one point that I think would clarify that: What P.S.I. is indicating is they would like to dispense with the guarantee renewable part of the contract with Schedule B so there wouldn't be any guaranteed renewable.

DR. LOCKHART: No, I don't think so, not as far as we are concerned, no.

DR. GALLOWAY: Why else would you want to delete that as a standard plan.

DR. LOCKHART: I think we must stick to the reasons we have given in the brief on pages 38 and 39. It wouldn't as far as we are concerned deprive the public of that type of coverage if they wish it and that we now have a plan similar to this suggested limited plan that we are prepared to continue to offer. I think other carriers have similar types of plans which they will indicate whether they are interested in carrying on. We feel the standard plan should be the one we should have.

THE CHAIRMAN: May I follow that through with one other question: It would be my interpretation if Schedule

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B were eliminated from the Act that Government subsidy for the type of plan that you are suggesting that might be the equivalent of Schedule B and available elsewhere, that that subsidy might not be available for them. Are you interpreting it that way?

DR. LOCKHART: Yes, but I think the recommendations are that these people who require subsidy should have comprehensive coverage rather than a limited plan.

MR. MAJOR: The Act sets that forth, doesn't it?

THE CHAIRMAN: I think so.

MR. MAJOR: There is nothing in the Act that the subsidy will only be paid on Schedule A.

DR. LOCKHART: Mr. Chairman, referring to the figures of our brown plan, Mr. Simon quoted 246,000 subscribers. This is actually 246,000 total participants. The number of subscribers is 97,000 and the growth lines are amplified on page 29 of our brown plan where in 1959 we had the number of participants enrolled, 344,000. This has dropped since that time to the end of June 1963 when it was down to participants at 246,000.

MR. SIMON: I was quoting out of memory. May I continue, Mr. Chairman?

THE CHAIRMAN: Yes.

MR. SIMON: Page 39, paragraph 98 you refer to

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MR. SIMON: Page 29, paragraph 38 you refer to

services "as ordinarily provided in the private practice of medicine." Could you define what about the physician that is working for an institution or a co-op or any pooling service or university hospital? I have in particular in mind the Sault Ste. Marie Steelworkers Experiment. Would these physicians be deprived, be the black sheep of the family or what?

DR. LOCKHART: This isn't the intent of this clause. The intent of this clause was to try and define the benefits available. It is those benefits, medical services, obstetrical services available to the subscriber for the services or the payment thereof as ordinarily provided in the private practice of medicine.

MR. SIMON: There are some cases that are not done ordinarily. Those are the things I have mentioned. They are exceptions. It is true, maybe 90% of the patients get attention by doctors that practice privately, but the other 10% may be getting it from institutionsor co-ops. I want to know what your interpretation is, the meaning of this?

DR. HINES: Mr. Chairman, Mr. Simon it defines the degree of benefits. It doesn't really refer to which doctors will receive the payment from the Corporation. This particular paragraph specifies it will be as ordinarily provided in private practice of medicine. It is not a usual practice of doctors in Ontario to give back rubs to individual

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patients at home.

MR. SIMON: To give what?

DR. STIVER: To give a back rub. The doctor may do so if he decides it is a muscle spasm and he can rub the knot out. It wouldn't be part of my regular day to provide physio-therapy in the home. This isn't a usual thing for doctors in my community to do, and therefore if I started submitting accounts to P.S.I. for massage to back on a daily basis then P.S.I. would say this isn't the normal thing in the community. This isn't a benefit. If I make a house call to see how lumbago is doing, then this is a different thing. This, of course, isn't to define which doctors would receive the payments but defines the nature of the benefits which will be paid.

DR. LOCKHART: The other point that might be clarified really entering institutions that are not covered on page 40 of the recommendations number (ii):

> "When the covered person is a patient under the care of a sanatorium, institution or special hospital for tuberculosis, mental illness or disease, alcoholism or epilepsy, or as a drug addict, or when the covered person in question should properly be such a patient ---"

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"When the insured person is a patient under the care of a sanatorium, institution or special hospital for tuberculosis, mental illness or disease, alcoholism or epilepsy, or as a drug addict, or when the covered person in question should properly be such

This really is to cover the medical services which are not at the present time covered as private services, where the medical services are provided by some other means, not the responsibility of the individual. We feel at the present time that these should be exclusions because this is the way it is paid at the present moment in the Province of Ontario.

MR. SIMON: Coming, Mr. Chairman, to page 40 the paragraph Dr. Lockhart just quoted. There are a few things not clear to me:

"Should properly be such a patient, or services for which no charge would be made in the absence of insurance". If there is a borderline case where a person decides not to go to an institution and chooses to be treated by a private doctor, the carrier may then say we are not going to pay this because the person should be in the institution , of if there is an outpatient service in a hospital which means I may have to sit there half a day and I just go to a doctor, the carrier may say we could have got that service in another place. I would like some clarification as to the meaning of words.

DR. STIVER: The question, Mr. Simon, you asked about special institutions, the covered person ought probably have such benefits. As you know it is laid out in our present agreement with subscribers. It is placed there for a control feature only. In the life of P.S.I. we have

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DR. SILVER: The question, Mr. Simon, you
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used that clause, I think, on two occasions, that particular clause. Drug addiction is one of which you are not on. The second question:

"Should properly be such a patient, or services for which no charge would be made in the absence of insurance". I don't think we are trying to channel the citizen, where he should get his medical care. That covers the services of interns, people like that on which no charge is made.

MR. SIMON: I think that would need better spelling out of what is intended by this. P.S.I. may be a splendid carrier and be fair with our subscribers, but you may have others that would give a different interpretation of what goes into the Act.

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DR. STIVER: We foresee some difficulties on that point sir.

MR. SIMON: Page 41, to clarify what you mean by "pursuant to an arrangement for rendering services to the employees of an employer or to members of an Association --" now that is kind of a broad thing.

DR. STIVER: Our interpretation is we think this is really industrial medicine. There are two problems which give us some difficulties: Industrial medicine and mass group innoculations within a group for which arrangements are made for the group. As you know, ordinary innoculations are within our plan but that is on a citizen's election of his own doctor in the private practice of medicine.

MR. SIMON: On the same page, at the bottom, well-baby care you suggest ten visits in the physician's office during the first five years of life. Do you feel that is sufficient?

DR. STIVER: Yes. We changed this two years ago and we think it is now, with that limited experience -- if you consider two years limited experience -- this, I would say is satisfactory.

THE CHAIRMAN: May I ask one question? If you had the whole ten in one year, do you still pay them?

DR. STIVER: Yes. Then the time is up.

MRS. AYLEN: May I ask a question? Would those

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DR. SMITH: Our interpretation is we think this is really industrial medicine. There are two problems which give us some difficulties: Industrial medicine and mass group inoculations within a group for which arrangements are made for the group. As you know, ordinary inoculations are within our plan but that is on a citizen's election of his own doctor in the private practice of medicine.

MR. SIMON: On the same page, at the bottom, well-nigh sure you suggest ten visits in the physician's office during the first five years of life. Do you feel that is sufficient?

DR. SMITH: Yes. We changed this two years ago and we think it is now, with that limited experience -- if you consider two years limited experience -- this, I would say is satisfactory.

MRS. CHRISTMAN: May I ask one question? If you had the whole ten in one year, do you still pay them?

DR. SMITH: Yes. Then the time is up.

MRS. AYRES: May I ask a question? Would those

ten visits cover all innoculations and boosters, and so on?

DR. STIVER: In the ordinary private practice of medicine today in Ontario, it is adequate and, in fact, if the citizen used them judiciously, he can get his pre school examination through, if he watches the ages of his child very carefully and that is the reason why we went up to five years. This is on the recommendation of the pediatrician that we have written it that way.

MRS. AYLEN: Thank you.

MR. SIMON: Page 45---

THE CHAIRMAN: May I interrupt you? I am thinking we want to carry on until possibly a quarter after one, if that is necessary, and if we do that, we don't want to leave too long a stretch here.

MR. SIMON: I don't think I will be too long; maybe another couple of questions.

THE CHAIRMAN: Would you have any objection if we just take a break here?

MR. SIMON: No. I am all for it.

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THE CHAIRMAN: Ladies and gentlemen, we will carry on. Mr. Simon was doing the questioning.

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THE CHAIRMAN: Ladies and gentlemen, we will carry on. Mr. Simon was doing the questioning.

MR. SIMON: Dr. Lockhart on page 45 paragraph 111 you recommend that "guaranteed renewable means the right conferred upon a covered person, in the absence of misrepresentation, misuse of service or non payment of subscription..." Now who would determine the misrepresentation or misuse? It's quite a broad statement. Would you leave it to the carrier to determine or would there be an appeal board for a person that was denied the continuing subscription? What are your views on that?

DR. STIVER: Mr. Chairman, certainly within P.S.I. we have no outside Appeal Board. You would have probably read here in the appendices there is an Appeal Board in P.S.I. -- that is the Executive Committee. When you come to a standard plan, whether or not there should be an outside Appeal Board, I think we could support that, if the Government so desires.

I think you have or if you haven't you may have heard some briefs do take that into consideration. We did not go to the detail in this here, although we feel very strongly about that one point, the misuse, and that is based purely on our experience.

MR. SIMON: Don't misunderstand me. I am not condoning misuse or misrepresentation. There should be some means by which the person can appeal.

THE CHAIRMAN: May I interject? Your comments there lead me to conclude that there is a fair amount of misuse?

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DR. STIVER: No, Mr. Chairman. I think it would be wrong to say that. I think we must keep things in perspective. When you think P.S.I. has now one million eight hundred thousand people, men women and children covered, and the number of participants that we have really had to do something about, I am talking now from memory, we have probably contacted up to 500 down through the years, but we have really done something about less than 75 and to bring that up further, we have denied or cancelled our subscribers' agreements only in possibly less than two dozen cases so I do not think you should construe that serious misuse is widespread with that experience.

THE CHAIRMAN: Thank you.

MR. SIMON: Here again, of course, you based your experience on your own organization?

DR. STIVER: Yes sir.

MR. SIMON: There are others in the field too, of course.

DR. STIVER: Yes, and they are usually asked the same question.

MR. SIMON: No doubt they will. On page 47, article 3(b) paragraph 119 you recommend that the persons eligible for assistance would be those whose income exemptions are equal to or greater than their income.

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If I interpret that correctly, it means that a family with one child would be entitled to earn up to approximately $2350.00 a year and if he earns less than that, or that much, he gets subsidy. Otherwise, he would be out in the cold.

You feel this is an amount sufficient for a person to be able to pay for his own insurance?

MR. BOND: This is an area that we feel you have to set some standard. As in everything else, there will be cases which will have to have individual consideration, and it would be difficult to say whether that person could or could not afford to pay for his medical care.

We have tried to establish here some basis which, from a practical standpoint, could be administered. Therefore, it is a difficult question to answer categorically.

MR. SIMON: I appreciate your thoughts on that. In that brief you certainly are, in my opinion, away below any subsisteme amount for a family in the present day and age to be able to carry on, to have to pay their own insurance, and that only 70%.

DR. HINES: We all realize that how much money we would like to have for things varies with individuals, and the setting of any level is going to be arbitrary. Inasmuch as the profession wanted to, in this Corporation wanted to get away from the setting of an arbitrary limit, they thought that the Government had already set a limit, the

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Government thinks that $2350.00 for a couple with one child, as you suggested, this man is not in a position to pay for the armed services and the cost of Government in Ottawa and all the multiplicity of service that he receives in the general run of life, but if the Government thinks at that level he is fair game for total services, that he should be fair game to look after himself. We think that if $2350.00 is not a fair level for him to be responsible for himself, then the Government should not be taxing him at that level and that if representations were to be made that the $1,000.00 reduction for an individual should be $1500.00 I, as an individual, may support that across the country but this relieves the Corporation of being given an arbitrary capacity.

MR. SIMON: You and I could sit and debate this thing all afternoon. On page 57 you talk about indigent cases, and you suggest that the profession is now looking after some of the indigents without any charge, and then you say in paragraph 149:

> "If it should come about that the Government and the medical profession decide not to use the established organization for the indigents then P.S.I. would be prepared to co-operate with Government for the provision of standard medical services insurance contracts for these people."

Would you be prepared to provide that service at a lower rate than the normal rate, or would you still want to charge the prevailing rate, taking into consideration that the profession is now giving gratis service.

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DR. LOCKHART: Mr. Chairman, it doesn't matter what we say, because as a practicing physician the Medical Welfare Plan pay doctors for out of hospital service at very much the same method as P.S.I. pays and we are, first of all, recommending that this could be extended and then that if this is not -- if it does not meet the requirements of Government, that we would be pleased to assist the Government in seeing that these people could be covered.

THE CHAIRMAN: May I be given a nickle's worth on that one? Do I understand your statement there to mean that the $1.25 per person for indigent as set up under Schedule C here which the Government provides through the Ontario Welfare Plan is enough to provide 90% of the physicians' charges to these people, when you said similar to what P.S.I. requires for the service rendered?

DR. LOCKHART: For the service rendered purely and simply out of hospital.

MR. SIMON: You still have not answered my question. Would you be willing to provide at the same rate that Government now pays for the indigents or would you want a standard plan at the standard rate?

DR. LOCKHART: If this is in fact through the Medical Welfare Plan, then I think this is entirely up to the profession and to Government to negotiate a rate. On the other hand, I would feel that if it is going to be handled

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through private carriers, then it should be handled in the same way as any other coverage. Now there may be certain modifications.

MR. SIMON: P.S.I. is not a private carrier? Do you class yourself as a private carrier the same as any insurance company?

DR. LOCKHART: No.

MR. SIMON: No answer?

DR. STIVER: We said no.

MR. SIMON: You are supposed to be a non-profit organization.

DR. HINES: That is right.

MR. SIMON: One more question Mr. Chairman. You make reference in your brief, on page 60, to some meetings, even mentioned it's a meeting of the Committee as a whole on February 27 1963, and this deals with pooling arrangements; then in your supplementary letter to this Committee of December 5th, you make a further reference to it. What kind of meetings are you talking about? I would like to know what you mean by meetings. Who participated in these meetings? Do you expect this Committee to be bound by any discussion or decision at any private meetings?

DR. LOCKHART: No. It is true that we did attend at certain meetings, but it was entirely with the understanding that we are not bound by any decision at any

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MR. WHITNEY: Those were meetings of the Committee as a whole of the Legislature, were they not, prior to the drafting of the legislation is that what we are referring to?

THE CHAIRMAN: No.

DR. LOCKHART: No, it is not.

MR. SIMON: These are other kinds of meetings.

MR. WHITNEY: What kind were they? I am still wondering.

THE CHAIRMAN: I think probably I can answer that because I do have information here, and I believe it is also available to members of the Committee. From what we have been supplied with here, they were meetings held by people to give the Department of Health guidance in drafting the Bill that has been set up. This is one of those meetings I think that you are referring to here?

MR. WHITNEY: I am aware of those meetings. This is the meeting then we are talking about?

DR. LOCKHART: Yes.

THE CHAIRMAN: Mr. Whitney?

MR. WHITNEY: On page 21 you set out the summary of financial statistics and looking that over I was wondering is P.S.I. under any obligation to maintain a certain

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MR. WHITMORE: On page 21 you set out the

[illegible] is P.S.I. under any obligation to maintain a certain

reserve in cash on investments, certain obligations statutory or regulatory-wise under the Department of Insurance or any other Department?

DR. LOCKHART: There is no legal requirement that sets out a specific amount, such as the number of months for medical accounts, medical expenses, anything of this sort. This is an area that is very difficult to determine. I think if you spoke to 20 prepaid clients, you will get possibly 20 different answers as to the amount which should be set up in that stabilization fund. We do not like to see this provision get too high, and yet there has to be an amount there to take care of an epidemic that might arise, to give time to assess our position, to determine what we should do. The answer to your question really is no. There is no legal requirement.

MR. MAJOR: I would like to, if I may, sir enlarge on that a bit. The Superintendent of Insurance of the Province of Ontario has the power to control or to advise in the setting of rates in view of the resources that are in the Corporation and this is so with any organization that is licenced under the prepaid Ontario Medical Services Act. The Superintendent has broad powers here but he has no standards nor is there anything set forth in the Act there must be a particular amount of money or a particular set of circumstances.

MR. WHITNEY: If all the bills received by you on hand say today were paid would the general reserve be

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adequate to meet all the accounts or cheques issued today? I am thinking of the lag in payment from the time you get the bill to the time that you clear up.

MR. NAYLOR: Not only that is received actually in hand, but those incurred up to the present time.

MR. WHITNEY: Well you can add that too.

MR. BOND: No, the cash in reserve would not today cover all of the bills, not quite. The amount shown in that actual general reserve, the build-up in your assets, and so on, there is certainly sufficient funds to carry and to pay for the accounts that would be rendered -- get down to all the details of this -- certainly the Corporation is solvent; would not go out of business if it had to stop taking income today. There would be sufficient money to cover, through assets and so on. There are sufficient funds.

MR. NAYLOR: There is some provision for that besides your general reserve?

MR. BOND: Yes, there is a provision, a liability set up for the particular services that we estimate to be outstanding.

MR. NAYLOR: And this general reserve is in addition to that?

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wonder if I may make a correction on this table while it is in front of us and that is in the general reserve underlined for 1962 and the accumulation which, of course, is the same amount, the amount of $3,287,291.00 is an error. This should be $3,244,295.00.

MR. WHITNEY: To get a little bit more pointed on the figure picture, in the expenditures for 1962 there was a $42,000,000. expenditure. That is about three and a half million a month. So you are incurring accounts at the rate of three and a half million a month and you have a general reserve of about three million too. How do you work your ratio? How do you know whether you are well enough reserved, I mean just particularly from your point of view?

MR. BOND: We look at our reserve and attempt to determine have we got -- after setting aside an amount to pay for these outstanding accounts -- have we a sufficient amount of money in reserve to permit us to continue paying our accounts until we can make a decision as to whether or not rates should be increased; whether there would be some deduction in the amount paid to the participating physicians. It's primarily to give us time to see the trend in our medical payments.

MR. WHITNEY: And you think one month's payment in reserve is sufficient do you? Is that what you are saying?

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THE CHAIRMAN: There is a drop here of almost 50% in one year.

MR. BOND: Yes.

MR. NAYLOR: Did I understand you Mr. Bond to say that you have another reserve besides this general reserve for your outstanding liabilities or claims?

MR. BOND: Yes. In 1962, for instance, our Annual Report we show a current liability of something over $7,000,000. Now this is to cover the services that would be rendered in the last month or two of the year for which we pay in the following year. We then have set up a provision for unregistered services, assuming around $2,500,000. This is an estimate of the amount of outstanding accounts that have yet to be rendered to our Corporation and are charged against that current year's income.

MR. NAYLOR: I was going to ask the amount. I think you have answered it. You have a $7,000,000. plus a two and a half million dollar liability set up.

MR. BOND: Yes, for outstanding accounts.

MR. WHITNEY: May we have one of the annual statements filed with the Committee?

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MR. BOND: Yes. We brought copies for the Committee and we will pass them out to you at the end of this meeting.

MR. WHITNEY: Of course, in your peculiar situation then I suppose it would be fair to say that you have an intricate or hidden reserve for the physicians' services? I mean the practitioners who are tied with you?

MR. BOND: That is right.

DR. STIVER: Very definitely.

MR. WHITNEY: Tell me, in the community business that you have developed, from the experience that you have had, is it considered a large number of enrolment, percentage-wise, in the community? Does this put the doctor who is not tied with you at a great disadvantage or some disadvantage in the practice of medicine if he is not tied with you under agreement?

DR. LOCKHART: No. We make no limitation, as far as non-participating doctors providing services for patients under the P.S.I.

MR. WHITNEY: Would you say that again?

DR. LOCKHART: We make no limitation on the provision of medical care by non-participating physicians.

MR. WHITNEY: No, but I mean a chap who is not tied with you, if the people say well we are under P.S.I., are you under agreement with them? And he says no, would there

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be a tendency to discourage the use of that doctor? I mean how have you found it from experience?

DR. LOCKHART: Theoretically I suppose it could be, and yet from experience I have not heard of any great repercussions.

MR. WHITNEY: In the communities in which you have developed the service?

DR. STIVER: Mr. Chairman, I think if you could plot, Mr. Whitney, our enrolment in physicians across the Province, as a general statement the higher our enrolment the higher our participating physicians.

MR. WHITNEY: That might be the answer.

DR. STIVER: Does that answer your question? There are exceptions to that too, but as a general statement.

MR. WHITNEY: That could be the answer to my question. On this question of extra billing, am I clear that you state that when an individual is earning over $7,000.00 that you have no objection to extra billing?

DR. LOCKHART: That is correct.

MR. WHITNEY: For a family and dependents, if there is an aggregate income in that family and dependents living at home of $10,000.00 you will allow extra billing?

DR. LOCKHART: Yes.

MR. WHITNEY: In connection with specialists?

DR. STIVER: Both general physicians and

be a tendency to discourage the use of that doctor? I mean how have you found it from experience?

DR. LOCKHART: Theoretically I suppose it could be, and yet from experience I have not heard of any great repercussions.

MR. WHITNEY: In the communities in which you have developed the service?

DR. STIVER: Mr. Chairman, I think if you could plot, Mr. Whitney, our enrolment in physicians across the Province, as a general statement the higher our enrolment the higher our participating physicians.

MR. WHITNEY: That might be the answer.

DR. STIVER: Does that answer your question? There are exceptions to that too, but as a general statement.

MR. WHITNEY: That could be the answer to my question. On this question of extra billing, am I clear that you state that when an individual is earning over $7,000.00 that you have no objection to extra billing?

DR. LOCKHART: That is correct.

MR. WHITNEY: For a family and dependents, if there is an aggregate income in that family and dependents living at home of $10,000.00 you will allow extra billing?

DR. LOCKHART: Yes.

MR. WHITNEY: In connection with specialties?

DR. STIVER: Both general physicians and

specialists, they may extra bill. For those services for which we pay a specialist fee, they can only extra bill if income is high.

MR. WHITNEY: And the doctor asks the patient what his income is; is that the idea?

DR. STIVER: We leave it up to them to work it out. We provide no information.

MR. WHITNEY: Back to the community enrolment plan, again. After you enroll a community, I am assuming that you have them long enough to get into the renewal position. Do you make any selection on renewals?

MR. WILLIAMS: When you say "selection", do you mean changing the rates for each individual or by eliminating certain people in a year?

MR. WHITNEY: Those included.

MR. WILLIAMS: No. We do not do that. We just go in and make it available to everyone.

MR. WHITNEY: And on renewals, you do not look at your experience of any particular individual?

MR. WILLIAMS: No.

MR. WHITNEY: I do not think I have anything else, Mr. Chairman.

THE CHAIRMAN: Mr. Mulrooney?

MR. MULROONEY: Dr. Lockhart, you stated that you have no distinction as far as--- On page 7, paragraph

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MR. MUIRHEAD: Dr. Lockhart, you stated that you have no distinction as far as--- On page 7, paragraph

36 of the brief, you say: "The subscriber, on some reasonable ground, may elect to obtain services from a non-participating physician." Then on page 43, paragraph 103, you state: "However, a subscriber has the privilege of receiving services from a non-participating physician..." That word "privilege" bothers me. Is it a privilege or is it not a person's right to go to the doctor of his choice?

DR. LOCKHART: Possibly we are in error. This may well be a bad word. Our interpretation of it is that the patient chooses to go to a non-participating physician.

MR. MULROONEY: In other words, you agree that it is his right to go to a non-participating physician?

DR. LOCKHART: Yes.

MR. MULROONEY: But in your agreement issued to a subscriber, Section 2, subsection 4 of your Terms and Conditions, you state that the Corporation may at any time, on seven days' notice in writing to the subscriber, cancel his right and that of his dependent to obtain services from one or more non-participating medical practitioners as provided in paragraph 3 above.

DR. STIVER: That is placed there, Mr. Chairman, for nothing more than a control feature. We have just as strong control through our participating physicians' agreement; but in the case of non-participating physicians, for subscriber's care, there we haven't that control and it

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was written that way to give us that control.

In the last fifteen years that we have been in business, we have used that clause on three occasions.

MR. MULROONEY: But the policy of the Corporation, as stated in its own brief and the appended documents, means that P.S.I. -- to restrict, to some extent, the right of choice of doctors?

DR. STIVER: For very good reasons, that is true.

MR. MULROONEY: This is the answer that I wanted.

THE CHAIRMAN: May I ask a question? Do you have any knowledge as to whether or not other insurance carriers have similar clauses relative to -- it wouldn't be physicians that are participating with them -- but any particular physician, that enables them to stop payments, benefits, to people who work with a particular physician?

DR. STIVER: In the prepaid plans, professionally sponsored prepaid plans something along the line that we have is quite common. I cannot speak for the old line insurance companies. Mr. Williams can answer that.

MR. WILLIAMS: I can't think of a specific instance, but I am very sure that other group contracts do have clauses of this sort.

DR. GALLOWAY: The best example would be the

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DR. CARROWAY: The best example would be the

Workmen's Compensation Board, who have the right to restrict both the patient and the physician.

MR. MULROONEY: On page 9, paragraph 45, you mention five Ontario communities and tell us that community enrolment has been carried out in those communities. In the next paragraph you list eleven provinces and further on in the brief you tell us that P.S.I. proposes to continue this type of community enrolment throughout the Province.

I am concerned with the effect that this policy must have, both on health services insurance in the Province and on the doctors of the Province. I believe you have stated that the enrolment of participating physicians has corresponded approximately with the growth of P.S.I.; but does this not mean simply that your methods of enrolment and methods of application -- that you are compelling the doctors of the Province to participate in P.S.I.? Is this not the effect of this policy and its operation?

DR. LOCKHART: I can answer that by saying no, probably with certain qualifications.

After all, P.S.I. was set up by the physicians of the Province of Ontario in 1947 and, as such, most physicians have a very direct interest in the workings of P.S.I. And the statement was made that, yes, as we find, P.S.I. becomes more prevalent in a community, I think it is that the doctors become more interested in P.S.I....

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DR. LOCKHART: I do not think that is true. I know plenty of doctors who do not participate in the P.S.I., but make a good living.

MR. MULROONEY: This is quite possible. Nevertheless, the policy as of last year, if pursued, means that P.S.I. must dominate health services insurance in the Province and they must control the doctors of the Province.

THE CHAIRMAN: What do you mean by "control"?

MR. MULROONEY: They must accept 90% of the O.M.A. fee schedule as payment for their services, for example.

THE CHAIRMAN: Have you any comment Dr. Hines?

DR. HINES: Mr. Chairman, Mr. Mulrooney is making a very good point about the individual not having his rights abrogated and we certainly acknowledge the citizen's right to not purchase our plan, or anything which he finds unpalatable about the overall service, he has the election not to belong.

As far as the correspondence between the participation of physicians in a community in P.S.I. and enrolment among subscribers, it is very difficult to say which comes first. The question that we have a high participation of physicians in those communities which have been

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enrolled there is tribute to the fact that P.S.I., the success of the Corporation, rests on the physician himself being an active sponsor of the organization. P.S.I. is reluctant to make any overtures to the public in areas in which the profession itself does not offer spontaneous support to the organization.

There have been specific instances where the medical profession in some localities does not go along 100% with the policy of the P.S.I. and if there is any resistance, we do not go in. So it is difficult to say that the fact there is a high enrolment -- which comes first and which comes second? It is fair to say that the percentage of physicians enrolled in P.S.I. is always higher across the Province than the subscriber level. The subscriber level is steadily going higher and the physicians' is going higher, but it started out high, around 70 to 75% and it has moved up to 85%. Among the public, it started out at zero and in this community it has gone up to 60%. So I think endorsation by the profession certainly comes first.

MR. MULROONEY: Your brief states that P.S.I. has enrolment equivalent to 27.4% of the population, if I remember correctly, and if we include other doctor-sponsored plans, that percentage would increase somewhere between 30 and 35%; yet 90% of the O.M.A. schedule is paid to physicians who serve more than a third of the population. Can we not

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conclude from this, since this is operated by the doctors of the Province, the doctor-sponsored plans, W.M.S., P.S.I., A.M.S., if you wish -- that the correct fee schedule is actually 90%? In other words, does it not mean that the person who does not choose to join a doctor-sponsored plan or who decides that he can take care of his own medical expenses, is penalized by having to pay 100% or more of the O.M.A. fee schedule? Under this, does not the policy of P.S.I. and its operation in the Province have this effect?

DR. LOCKHART: I do not think it does, necessarily. Our plan was set up by doctors. The doctors have to carry an underwriting responsibility and for this underwriting responsibility it has made it possible to provide a service type plan to the people in the Province of Ontario -- not only in Ontario, but the same principle extends across Canada and across the United States.

The doctors do have a large measure of control, a large measure of authority over the operation of P.S.I., through their representation in the House of Delegates of P.S.I. and through their election from the House of Delegates, as outlined in our brief, to the Board of Governors. So that they do have, the doctors themselves, a controlling element in the operations of P.S.I. and for this, the underwriting feature, the participating physicians are willing to pay, really, the operating cost and contingency reserve.

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MR. CASWELL: It appears to me, just as layman, that 85% of the physicians are members of P.S.I. I assume almost 100% are members of the Ontario Medical Association. If the physicians are not receiving enough at 90%, the Ontario Medical Association simply raises the rate an extra 10% so they get enough.

MR. MULROONEY: You haven't looked at the increase in the 1962 O.M.A. schedule over 1958, I am afraid, Mr. Caswell.

MR. CASWELL: It is just a round-robin.

MR. MULROONEY: I concede, Dr. Lockhart, that the participating physicians contribute mightily to P.S.I. and the agreement which they signed astonishes me. I can't believe that if this form were submitted by any doctor to his lawyer that he would advise him to sign it.

As I read Section 4, Subsection 3, in substance it means that P.S.I., after setting aside what it considers necessary for its reserve, will distribute what remains to the doctors. He is guaranteed nothing. If he has any complaints or if any controversy arises with respect to payment, the decisions of P.S.I. are final and he has no other right, and for this he underwrites the organization. It seems to me that is a pretty bad deal for the doctors of the Province.

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DR. LOCKHART: It may sound that way, but

it simply has not worked out in practice. 85% of the doctors have chosen to become participating physicians. Certainly doesn't look as though the doctors think that.

MR. MULROONEY: I suggest that the policy of P.S.I. should consider the doctors, that the doctors have little choice, and this is the area that troubled me.

MR. MAJOR: I suppose that any organization has grown to some extent in a "Topsy"-like fashion from some concept. You must look back in a day when there was nothing available to citizens of this Province for the very basic insurance for physicians' services. This did not satisfy the medical profession, and the medical profession, in developing its approach, was willing to offer something to the public that nobody else had ever offered to them on a professional basis, and that was an anchor bolt, that for basic medical services they would see to it that the citizen would not be charged other than the subscription rate he was going to pay. This is the original concept.

You see, the medical profession were prepared, after a great deal of consideration, to guarantee something to the citizen that the citizen had never been guaranteed before. This concept turned out to be an exceptionally fine one.

THE CHAIRMAN: When you say the medical profession, you infer that this is a total agreement on behalf

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THE CHAIRMAN: When you say the medical

of the profession, and that is not correct. It is an individual agreement.

MR. MAJOR: No. I am talking about the original inception of the thinking by the Findings Committee of the Ontario Medical Association which, as an Association, voted that this be done, that this conception be implemented on a practical basis for the citizens of this Province. This is the background. This is the feature. This is the anchor bolt that the citizen was offered.

To make this anchor bolt solid, a legal agreement was required and that legal agreement as it stands today is essentially -- I do not think one word of it has been changed since the Findings Committee of the Ontario Medical Association developed it in the spring of 1947.

So that here we have a two-way agreement that if the citizens of this Province were prepared to pay a subscription rate, this organization sponsored by the Medical profession would guarantee to that citizen basic medical care without further charge, on certain income limits, and this concept has been developed to where it is now where it now includes many of the services of the spectrum. To twist this is like saying that General Motors should have developed a diesel engine before they developed an internal-combustion engine and that is not necessarily so. The concept was one that has proven itself and a long look must be taken at it

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before it can be twisted and say it should be something else.

MR. MULROONEY: May I make an observation on Mr. Major's remarks. There were carriers offering varieties of Health Insurance contracts long before P.S.I. came into the field or any of the doctor-sponsored plans. I am quite sure that insurance carriers and other carriers would have been very happy to develop a contract which would pay services in full if it had been possible at any time to come to agreement with the medical profession.

THE CHAIRMAN: I do not think that this line of discussion should be carried on.

MR. MULROONEY: I have no further questions.

THE CHAIRMAN: Dr. Butt and then Miss McArthur.

DR. BUTT: There is one little question: Can a non-participating physician become a Director on one of the Executive Committees of P.S.I.

DR. LOCKHART: No, the Charter says...

DR. BUTT: You have answered the question.

THE CHAIRMAN: Miss McArthur.

MISS McARTHUR: Mine is a very small one: I note that the exemption in health examinations was accepted by the brief. I wondered in considering that was it considered as an alternative that it might not be exempted but controlled to limitations as you have suggested in two other areas.

MR. MURROONEY: May I make an observation on

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MISS McARTHUR: Yet you were able to come through with the principle that the limitations of well-baby care were applicable.

DR. LOCKHART: This is so, yes, because really you are dealing with a growing, changing infant and in growing and changing, although it is classified as a well you are dealing with an infant that cannot talk, cannot tell you anything and cannot complain.

THE CHAIRMAN: Mr. Simon?

MR. SIMON: Dr. Lockhart, should the Ontario Government develop or in the future decide to put in a universal insurance plan paid for either through taxation or part taxation and part premiums by the public as was suggested in some of the briefs to us would P.S.I. be willing to lend their experience, their facilities, their organization to the Government in implementation of such a plan as did the Blue Cross in the Ontario Hospital Insurance Plan.

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DR. LOCKHART: It is something we would have to look at when the time arose. With the backing of the Ontario Medical Association we would do whatever was wanted at the time.

MR. SIMON: Thank you.

THE CHAIRMAN: Dr. Galloway.

DR. GALLOWAY: I have two comments and one small question. The first comment is I think this group should be complimented for delineating our areas of studies as they have done. They have indicated areas of studies, we maybe haven't recognized.

The other thing is something to clarify for the meeting in general, and I would refer to page 3 of Bill 163 in which the Minister may in accordance with the regulations,

> "(a) purchase standard medical services insurance contracts for such classes of persons as are set forth in Schedule C and who are in needy circumstances; and
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> "(b) contribute to the purchase of standard medical services insurance contracts for such other classes of persons as are set forth in the regulations and who are in needy circumstances."

Surely this means those who are in needy circumstances can't buy either the two standard contracts.

The only other thing, the only thing, the only question I have, because everthing else has been so well answered. I recall noticing the amount of your investment income ran close to $1,000,000.00, three-quarters of a million dollars a year. Does this go into reserves or general funds

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to reduce the premiums.

MR. BOND: This goes into reserves, and in turn would help to hold premiums in line. All the funds are there for the payment of medical accounts on behalf of the subscribers. It would hold the line.

DR. GALLOWAY: Holds the line but doesn't reduce the rates.

MR. BOND: It could reduce them.

DR. GALLOWAY: Thank you, sir.

THE CHAIRMAN: Any further questions.

MR. CASWELL: On that subject it would appear in 1962 you had a rather substantial deficit. It has resulted in an increase in premiums in 1963.

DR. LOCKHART: Yes.

THE CHAIRMAN: With the charge of $10.50.

DR. STIVER: Mr. Chairman, the reason '62 had a deficit was that we did two things without changing subscriptions. We went to a new schedule and increased certain benefits as of 1962. We let our reserves go down. This was a stated policy of the Board, Mr. Caswell and then there was no change in our subscriptions. Two or three other changes have occurred since January, 1963. This was a planned procedure worked through. It wasn't something that got beyond our control. I don't want you to get that impression.

THE CHAIRMAN: It was implied earlier here, I

MR. BOND: This goes into reserves, and in turn would help to hold premiums in line. All the funds are there for the payment of medical accounts on behalf of the subscribers. It would hold the line.

DR. GALLOWAY: Holds the line but doesn't reduce the rates.

MR. BOND: It could reduce them.

DR. GALLOWAY: Thank you, sir.

MR. CAUCHRIL: On that subject it would appear in 1962 you had a rather substantial deficit. It has resulted

THE CHAIRMAN: With the charge of $10.50.

DR. STIVER: Mr. Chairman, the reason '62 had a

January, 1963. This was a planned procedure worked through. It wasn't something that got beyond our control. I don't want you to get that impression.

THE CHAIRMAN: It was implied earlier here, I

believe, the plan under Schedule B wouldn't be eligible for subsidy the way the Act is now drafted. I don't think this is correct, in my interpretation of it. I could be wrong. I believe it is eligible for subsidy. One question: I would like to know why you haven't had any recommendations or included any recommendations relative to the times at which fees may be changed. Have you no concern about the suggestion that is in the Bill here. I think it is suggested the fees be considered every two years, if I recall correctly. I can't find the exact words. This is of no concern to you.

MR. SIMON: First two years and then every year after that.

DR. LOCKHART: We are in accordance with that, sir.

MRS. AYLEN: You have had so much of the medical profession here I would like to bring up something in the lay area, this is ambulance service. Have you any solution to whose responsibility they should be.

DR. LOCKHART: Well, the only -- it is not a solution, but in our extended health plan we do cover ambulance services.

MRS. AYLEN: Is it subject to abuse? Why is it.

DR. LOCKHART: Our extended health plan isn't too long in operation but it hasn't appeared a feature of abuse.

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It is a benefit.

MR. WILLIAMS: Mrs. Aylen, I have been reading about this controversy about ambulances and their problems because the patient doesn't usually order the ambulance and they can't collect the money. Well, this is in the extended care plan and the $50.00 deductible in our plan wouldn't help this situation at all if this is a situation we are coming to.

MR. CASWELL: Is your $50.00 deductible for a single incident or per year.

MR. WILLIAMS: Per year.

MR. CASWELL: They could add up all their extra payments and take $50.00 off.

MR. WILLIAMS: That is right

THE CHAIRMAN: Do the members of your delegation have any further comments.

DR. LOCKHART: I don't think so. We want to thank you for the privilege of appearing before you and trust we have been of some help.

THE CHAIRMAN: This has been very informative and very interesting. Thank you.

---Whereupon the hearing adjourned to 10:00 a.m. January 29th, 1964.

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